Australian Government
Department of Health and Ageing

Medicare Benefits Schedule Book

Operating from 1 November 2005

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

BOOK LAYOUT

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

. **Contents (black edging)**

. **Introduction**

. **Summary of Changes included in this Edition**

. **General Explanatory Notes**
(Includes an outline of the Medicare benefit arrangements and general notes for guidance for all services)

. **General Medical Services comprising**
- **Professional Attendances (Category 1) - (buff edging)**
- **Allied Health and Dental Care Services (Category 8) – (ochre edging)**
- **Diagnostic Services (Category 2) - (blue edging)**
- **Relative Value Guide (within Category 3) – (teal edging)**
- **Therapeutic Procedures (Category 3) - (red edging)**
(Includes specific explanatory notes preceding each category)

. **Index to General Medical Services (green edging)**

. **Approved Dental Practitioner Services (Category 4) - (grey edging)**
(Includes an outline of these arrangements, specific explanatory notes and an index)

. **Diagnostic Imaging Services (Category 5) - (purple edging)**
(Includes an outline of these arrangements, specific explanatory notes and an index)

. **Pathology Services (Category 6) - (yellow edging)**
(Includes an outline of these arrangements, specific explanatory notes and an index)

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INTRODUCTION

The book is divided into the following sections :-

- **General Explanatory Notes**
  (includes an outline of the Medicare benefit arrangements and general notes for guidance for all services)

- **General Medical Services** comprising
  - Professional Attendances (Category 1) - **(buff edging)**
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- **Pathology Services** (Category 6) - **(yellow edging)**
  (includes an outline of these arrangements, specific explanatory notes and an index)

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

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

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

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

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

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

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

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

Complete explanatory notes relating to the Medicare benefits arrangements for allied health and dental care services linked to Enhanced Primary Care (EPC) planning are located in a separate MBS booklet. An abridged version of the explanatory notes about the referral processes for these services, is included with the EPC explanatory notes (see A.21).

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

NSW - 132 150
VIC - 03 9605 7964
QLD - 07 3004 5450
SA - 08 8274 9788
WA - 132 150
TAS - 03 6215 5740
ACT - 02 6124 6362
NT - use South Australia number

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

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

NEW SOUTH WALES

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

VICTORIA

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

QUEENSLAND

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

SOUTH AUSTRALIA

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

WESTERN AUSTRALIA

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

TASMANIA

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

AUSTRALIAN CAPITAL TERRITORY

Scarborough House
Atlantic Street
PHILLIP ACT 2606
Tel (02) 6289 1555

NORTHERN TERRITORY

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

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

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

SUMMARY OF CHANGES INCLUDED IN THIS EDITION

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

From 1 October 2005, the Health Insurance Commission has changed its name to "Medicare Australia". All references to the Health Insurance Commission have been amended in this edition of the Medicare Benefits Schedule to read Medicare Australia.

General Fee Increase
The following changes to Medicare schedule fees will apply from 1 November 2005:

- A 2.0% increase in Schedule fees will apply to all items in Group A1 plus equivalent attendance items. There has been no increase in the Schedule Fee for items in Group A2 (other non-referred attendances), item 173 in Group A7 (acupuncture), Group A19 (PIP incentive payments, other non-referred);
- A 2.0% increase will apply to all other items except Diagnostic Imaging and Pathology items.

Increase in Maximum Gap Payment
The maximum patient gap between the Schedule fee and the benefits payable for out-of-hospital services increases to $61.50 as at 1 November 2005. The 85% benefit level will apply for all fees up to $410.00, after which, benefits are calculated at the Schedule fee less $61.50.

REVIEW OF GENERAL MEDICAL SERVICES

- **60 items in Group T8** have had the 85% benefit level removed following a review to identify those that are in-hospital services only.
- **Brain stem evoked response audiometry -** New note D1.10 explains that item 11300 can be claimed for the programming of cochlear speech processors.
- **Bone densitometry** – the Notes for Guidance associated with items 12312 and 12318 have been amended to clarify that the requirement that the patient's prolonged glucocorticoid therapy be for a period anticipated to last for at least 4 months, applies to both the inhaled and the oral medication. The Notes also clarify that the glucocorticoid therapy must be contemporaneous with the current scan.
- **Home dialysis -** Item 13104 has been introduced to provide for the planning, management and supervision of a patient on home dialysis by a consultant renal physician.
- **Intensive Care and Associated Services** – a number of changes have been made to intensive care and associated services to ensure they reflect current clinical practice:
    - New items have been introduced for counterpulsation by intraaortic balloon (13847) and initiation of ventilation (13881), to separate the procedural from the management components, in recognition that these components are often performed by different practitioners;
    - Initiation of ventilation items, covered by 13857 and 13881, have been clarified to specify that the service includes establishment of airway access;
    - A fee increase has been applied to items 13870, 13873, 13876, 13882, 13885 and 13888 in recognition of changed clinical practice and increased complexity over the last ten years. These services have also been amended to clarify that they must be performed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care; and
    - The Notes for Guidance have been amended to define "exclusively rostered" and "management" of counterpulsation by intraaortic ballooon.
- **Obstetrics -** An obstetrics item for the planning and management of a pregnancy beyond 20 weeks, previously introduced via a Ministerial Determination under Section 3C of the *Health Insurance Act 1973,* is being moved into the General Medical Services Table. The item was also renumbered from 15999 to 16590 to keep the obstetrics section sequential.
- **Botulinum toxin items -** Items 18360, 18362, 18364, 18366, 18368, which were previously covered under a 3C Ministerial Determination, and new items 18351 and 18371 (Dysport™ treatment of blepharospasm and hemifacial spasm), have been introduced following the finalisation of approvals by the Therapeutic Goods Administration for the indications involved. All items (18350-18371) are restricted to medical practitioners who are registered by Medicare Australia to participate in the Botulinum Toxin Program arrangements under Section 100 of the *National Health Act 1953.* A note has been added to clarify Medicare billing where the botulinum drug is not supplied and administered in accordance with the Section 100 arrangements, and is therefore not free of charge to patients.
- **Prostate Brachytherapy -** Items 15338 and 37220 have been amended to clarify the tumour (T) stages that are covered, following changes in the T classification introduced by the American Joint Committee on Cancer in 2002.
- **Relative Value Guide for Anaesthetics (RVG)** – several items have been introduced to address clinical situations not currently catered for and RVG units have been adjusted for some items to address anomalies in the relativities. Specifically:
    - Increase in base units for intranasal, intraoral and dental procedures (items 20160, 20170, 22900 and 22905) from 5 to 6 to differentiate these services from the more superficial head and neck procedures;

- Increase in base units for procedures done per vagina (item 20940) from 3 to 4 to differentiate these from external and surface procedures.
- Increase in base units for colporrhaphy, colpotomy and colpectomy from 4 to 5 base units to differentiate between simple external and surface procedures and more invasive internal procedures;
- Amendment to the time units from 15 minutes to 10 minutes for services 2 hours or longer, to address the current anomaly were short cases are valued disproportionately over longer cases;
- New items have been introduced for bilateral hip replacement (21216), ovarian malignancy (20847), endometrial ablation or resection in association with hysteroscopy (20953) and surgery on upper and lower anterior abdominal wall (20703 and 20803);
- A new item has been introduced (item 22018) to clarify the indications for respiratory monitoring during anaesthesia;
- Intra-operative intrathecal and epidural injections have been revised (items 22031 and 22036) to better reflect current clinical practice; and
- Item 21965 has been amended to preclude treatment for headache of any aetiology.

- **Sentinel lymph node biopsy -** Following a recommendation of the Medical Services Advisory Committee (MSAC), interim items 30299, 30300, 30302 and 30303 have been introduced for use of this procedure in patients with breast cancer. Medicare funding for these items is available for five years until November 2010, before which time MSAC will review the results of trials conducted in the intervening period.
- **General surgery -** A new item (Item 30024) has been introduced for debridement of extensively infected post-surgical incision or Fournier's Gangrene.
  - the Notes for guidance for item 30396 have been amended to include a definition of "major abdominal surgery".
  - Item 31340 has been amended to include a cross reference to all items in the range of 31255 to 31355 which corrected an oversight from the May supplement to the 1 November 2004 MBS.
  - Items 31350 and 31355 have been amended to define the term soft tissue under these items.
  - Items 31205-31330 to 31330 and 31345, 31346, 31400 and 31403 have been amended to better define lesion size claimable under these items.
- **Sacral nerve stimulation for faecal incontinence -** Following a recommendation of the Medical Services Advisory Committee, items 32213-32218 item have been introduced for use of this procedure in patients 18 years of age or older who have an anatomically intact but functionally deficient anal sphincter and faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, where not contraindicated.
- **Carotid percutaneous transluminal angioplasty with stenting -** Following a recommendation of the Medical Services Advisory Committee, item 35307 has been introduced for use of this procedure in patients with medical or surgical comorbidities that would make them at high risk of perioperative complications from carotid endarterectomy.
- **Cardio Thoracic -** The cardio thoracic section of the Schedule has been divided into sub-categories to allow similar procedural items to be grouped together. This has resulted in the renumbering of 24 items. Minor amendments to a number of descriptors have occurred to better describe the services.
- **Transvenous Pacing Leads -** A new item, 38358 has been introduced for the extraction of chronically implanted transvenous pacing or defibrillator lead or leads. A new note T8.58 explains the circumstances under which the item can be claimed.
- **Peripheral nerve stimulation** – Item 39138 has been amended to allow the payment of benefits, under the multiple operation rule, for the placement of up to four leads.
- **Ophthalmology**
  - Item 106 has been amended to reflect that the item is claimable when the sole service provided is refraction testing for issue of prescription for contact lenses or spectacles.
  - Item 42707 has been amended to exclude surgery performed for the correction of refractive error.
  - Items 42719, 42722 and 42731 have been amended to clarify the intent of the items that either service, or both, stated in the item descriptor may be claimed under the appropriate items.
  - Items 42722, 42725 and 42731 have been amended to reflect current practice and delete superfluous wording.
  - Item 42821 for ocular transillumination has been amended to remove the term "as an independent procedure" from the item, to reflect current practice.
  - New items have been introduced for needling of the encysted bleb post trabeculectomy (42744), surgical insertion of tantalum markers for choroidal melanomas (42805) and transpupillary thermotherapy (42811).
- **Plastic & Reconstructive surgery**
  - Explanatory note T8 .80 has been amended to define abrasive therapy under items 45021 or 45024
  - Explanatory notes T8 .85 has been included to define what is meant by revision of scar under items 45506 to 45518 and clarify claiming of associated flap services under these items
  - Explanatory note T8.86.1 and T8.88.1 have been amended to clarify that benefits are payable for either breast ptosis or augmentation mammaplasty on the same side.
  - Item 45533 has been amended by removing references to items 30165 to 30178 to reflect current practice and remove superfluous wording.
- **Orthopaedics -** A number of orthopaedic items are being amended to reflect current clinical practice. The amendment to item 50303 will clarify that payment is once per limb. The amendment to item 50306 allows for procedures where

the limb lengthening is greater than 5cm. A fee increase is being applied to items 50349 and 50351 to acknowledge the relative complexity of these items. Item 50350 is being deleted as the procedure is covered by item 50351.

CHANGES TO DIAGNOSTIC IMAGING SERVICES

Following assessment by the Medical Services Advisory Committee, two obstetric and gynaecological items, 55707 and 55708, have been introduced for nuchal translucency measurement during pregnancy - New note DIK.8.3 explains under what circumstances the items can be claimed.

CHANGES TO PATHOLOGY SERVICES

PA.2.2 Services Where Request Not Required

PA.2.2 (ii)(c) has been created to accommodate the introduction of two new pathologist determinable antigen detection items (69364 and 69365).

PA.3.2 Certain Pathology Tests Do Not Attract Medicare Benefits

There has been a wording change to the list of pathology tests that do not attract Medicare benefits to allow for the detection of the presence of human immunodeficiency virus (HIV).

PH.9 Approved Collection Centres (ACCs)

There has been a revision of the wording of PH.9 to reflect the full implementation of the Approved Collection Centres (ACCs) arrangements.

Group P2 - Chemical
Items 66711 and 66712 have been created for the testing of cortisol in saliva in the investigation of Cushing's syndrome and the management of congenital adrenal hyperplasia.

Group P3 - Microbiology
Item 69364 and 69365 have been created for detection of virus, microbial antigen or microbial nucleic acid not elsewhere specified in the PST. Items 69315, 69369, 69370, 69372, 69373, 69374, 69375 and 69376 have been deleted to decrease the complexity within the antigen items.

There has been a minor word change to items 69303, 69306, 69309, 69312, 69318, 69321 and 69363 to accommodate the new antigen detection items.

There has been a minor wording change to items 69384, 69387, 69390, 69393, 69396, 69399, 69405, 69408, 69411 and 69413 plus the addition of 69415 to accommodate the introduction of human immunodeficiency virus (HIV) testing.

Item 69486 has been created for high risk human papillomaviruses (HPV) testing in a patient who has received treatment for high grade intraepithelial abnormalities of the cervix.

Rule 4 (1) (a)
A change to rule 4 (1) (a) has been made to avoid any ambiguity regarding the ability for all claimable items to be claimed in each of the 6 occasions that a specimen may be taken.

A change to rule 4 (1) (c) has been made to clarify that the test must be rendered immediately after collection and a result issued before the collection of new samples and another test performed**.**

Rule 26
A new rule, rule 26, has been created to describe the requirements for pathologist determinable services provided under items 69364 and 69365.

Index to Pathology Services (Abbreviations)

The *Index to Pathology Services (Abbreviations)* has been amended:

- There is a specific item (66711) for the cortisol in saliva and this is reflected in the index
- There is a specific item (69486) for Human Papillomaviruses (HPV) and this is reflected in the index.
- There are general serology and pregnancy items that now allow for Human Immunodeficiency Virus (HIV) testing and this is reflected in the index.

ALLIED HEALTH AND DENTAL SERVICES

- There are changes to the allied health and dental care items:
  - The referral form has been modified and a copy will no longer be required to accompany Medicare claims. Please see explanatory note A.23.19 -23.21.
  - The method of counting patient eligibility for services will change from 1 January 2006. Please see explanatory note A.23.23.
  - The requirements for written reports back to the referring medical practitioner have changed. Please see explanatory note A.23.27.

- Links between new chronic disease management items (721-731) introduced on 1 July 2005 and access to Medicare rebates for eligible allied health and dental care services (items 10950-10977) are outlined in Explanatory notes A22 - 22.51

SUMMARY OF CHANGES

The 1 November 2005 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	H
(b)	amended description	I
(c)	fee amended	+
(d)	item transferred from Ministerial Determination)	¶
(e)	item number change	*

New Items

13104	13847	13881	18351	18371	20703	20803	20847	20953	21216	22018
22031	22036	23091	23101	23111	23112	23113	23114	23115	23116	23117
23118	23119	23121	30024	30299	30300	30302	30303	32213	32214	32215
32216	32217	32218	35307	38358	42744	42805	42811	55707	55708	66711
66712	69364	69365	69415	69486						

Deleted Items

720	722	724	726	728	730	13845	13879	22030	22035	23090
23100	23110	23120	23130	23140	23150	23160	50350	66689	66692	69315
69369	69370	69372	69373	69374	69375	69376				

Amended Description

106	903	2517	2574	2620	2704	10950	10951	10952	10954	10956
10958	10960	10962	10964	10966	10968	10970	10975	10976	10977	11503
13857	13870	13873	13876	13882	13885	13888	15338	15360	15363	15541
21965	30023	31205	31210	31220	31225	31235	31300	31310	31315	31325
31330	31340	31345	31346	31350	31355	31400	31403	37220	38390	38450
38452	38473	39138	42707	42719	42722	42725	42731	42821	45533	47684
47687	47690	47693	50303	50306	55700	55703	55704	55705	69303	69306
69309	69312	69318	69321	69363	69405	69408	69411	69413		

Anaesthetic Unit Values Amended

20160	20170	20940	20942	22900	22905	23170	23180	23190	23200	23210
23220	23230	23240	23250	23260	23270	23280	23290	23300	23310	23320
23330	23340	23350	23360	23370	23380	23390	23400	23410	23420	23430
23440	23450	23460	23470	23480	23490	23500	23510	23520	23530	23540
23550	23560	23570	23580	23590	23600	23610	23620	23630	23640	23650
23660	23670	23680	23690	23700	23710	23720	23730	23740	23750	23760
23770	23780	23790	23800	23810	23820	23830	23840	23850	23860	23870
23880	23890	23900	23910	23920	23930	23940	23950	23960	23970	23980
23990	24100	24101	24102	24103	24104	24105	24106	24107	24108	24109
24110	24111	24112	24113	24114	24115	24116	24117	24118	24119	24120
24121	24122	24123	24124	24125	24126	24127	24128	24129	24130	24131
24132	24133	24134	24135	24136						

Fee Amended

13870	13873	13876	13882	13885	13888	20160	20170	20940	20942	22900
22905	23170	23180	23190	23200	23210	23220	23230	23240	23250	23260
23270	23280	23290	23300	23310	23320	23330	23340	23350	23360	23370
23380	23390	23400	23410	23420	23430	23440	23450	23460	23470	23480
23490	23500	23510	23520	23530	23540	23550	23560	23570	23580	23590
23600	23610	23620	23630	23640	23650	23660	23670	23680	23690	23700
23710	23720	23730	23740	23750	23760	23770	23780	23790	23800	23810
23820	23830	23840	23850	23860	23870	23880	23890	23900	23910	23920
23930	23940	23950	23960	23970	23980	23990	24100	24101	24102	24103
24104	24105	24106	24107	24108	24109	24110	24111	24112	24113	24114
24115	24116	24117	24118	24119	24120	24121	24122	24123	24124	24125
24126	24127	24128	24129	24130	24131	24132	24133	24134	24135	24136
50349	50351									

New Item (previous Ministerial Determination)

18360	18362	18364	18366	18368

Item Number Change

Old	New	Old	New	Old	New	Old	New
15999	16590	38743	38272	35304	38300	35305	38303
35310	38306	35335	38309	35338	38312	35341	38315
35344	38318	35347	38321	35350	38324	35353	38327
35356	38330	38278	38350	38281	38353	38284	38356
38406	38359	38606	38362	38521	38390	38524	38393
38400	38800	38403	38803	38409	38806	38410	38809
38412	38812						

Items with 85% Benefit level removed

32045	32047	32057	32069	32094	32103	32104	32115	32120	32153	38278
38281	38284	41512	41524	41527	41581	41629	41671	41689	41707	41716
41737	41749	41804	41813	41849	41852	41855	41858	42503	42510	42515
42518	42527	42539	42542	42554	42662	42698	42701	42702	42703	42707
42716	42722	42725	42746	42758	42833	45019	45218	45503	45568	45597
45625	45686	45732	45752	45761						

Items with 85% Benefit reinstated

35304	35305	35310	38203	38220	38243	38256	38270	38275	42771	45641
46375										

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

Where an item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 November 2005 and continues beyond that date, the general rule is that the 1 November 2004 level of fees and benefits would apply.

GENERAL EXPLANATORY NOTES

MEDICARE BENEFIT ARRANGEMENTS

1. OUTLINE OF SCHEME

1.1 Medicare

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

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

- automatic entitlement to benefits in respect of professional services (other than professional services to which the following dot points apply) equal to 85% of the Medicare Benefits Schedule fee, with a maximum payment of $61.50 (indexed annually) by the patient for any one service where the Schedule fee is charged;
- for professional services rendered while hospital treatment (ie accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility (other than public patients), a flat rate of benefit of 75% of the Schedule fee, that is, there is no limit to the maximum amount of gap between the benefit and the Schedule fee;
- benefits equal to 100% of the Schedule fee for non-referred attendances by a general practitioner to non-admitted patients and for services provided by a practice nurse on behalf of a general practitioner; and
- access to public hospital services for eligible persons who choose to be treated free of charge as public patients in accordance with the provisions of the 2003-2008 Australian Health Care Agreements.

Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee, or for amounts in excess of the Schedule fee where the patient has an arrangement with their health fund. For out-of-hospital services the maximum amount of 'gap' (ie the difference between the Medicare rebate and the Schedule fee) payable by a family group or an individual in any one calendar year is $335.50 (indexed annually from 1 January). Thereafter, patients are reimbursed 100% of the Schedule fee. Under the extended safety net, Medicare will meet 80% of the out-of-pocket costs (ie the difference between the fees charged by the doctor and the Medicare benefits paid) for out-of-hospital medical services, once an annual threshold of $306.90 (this will increase to $500 from 1 January 2006) for families in receipt of the Family Tax Benefit Part A and concession card holders, or $716.10 (this will increase to $1000 from 1 January 2006) for all other individuals and families is reached. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25. Individuals do not need to register with Medicare for the safety net threshold. However, families are required to register with Medicare to be eligible. Registration forms can be obtained from Medicare offices or completed online at www.health.gov.au or www.medicareaustralia.gov.au .

1.1.3 Medicare Australia is responsible for the operation of Medicare and the payment of Medicare benefits. For details of locations of Medicare offices, see paragraph 2.9 below.

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

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

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

1.1.7 Where a Medicare benefit has been inappropriately paid, Medicare Australia may request recovery of that benefit from the practitioner concerned.

1.2 IMPORTANT INFORMATION REGARDING MEDICARE BENEFITS AND BILLING PRACTICES

This section sets out the conditions under which Medicare benefits can be paid. These conditions are established in the *Health Insurance Act 1973* and associated Regulations. Detailed specifications on billing procedures are provided in Section 7 of these notes on page 13.

1.2.1 General requirements

The *Health Insurance Act 1973* provides that Medicare benefits are payable for professional services:

- A professional service for the purposes of Medicare is a 'clinically relevant service' that is listed in the Medicare Benefits Schedule (MBS).
- A service is clinically relevant, if it is a service provided by a doctor that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient receiving the service.

1.2.2 Payment of Medicare benefits

Specific information must be included in an account or receipt for a professional service for a Medicare benefit to be payable for that service.

This information includes the fee the doctor has charged for providing the service set out in the Medicare Benefits Schedule (a full list of required information is provided in Section 7 – Billing Procedures on page 13).

Doctors are free to determine their own fees for professional services. However, the amount that is specified in the account must be the amount charged for the service that is specified. The fee cannot include any component for other goods or services that are not part of the specified MBS item.

1.2.3 Billing practices contrary to the Act

The following illustrate billing practices that are not permissible under the *Health Insurance Act 1973*.

1. *Including the cost of a non-clinically relevant service in a consultation charge*

- Medicare benefits can only be paid in respect of clinically relevant services. A clinically relevant service is one that is generally regarded by the medical profession as being necessary for the appropriate treatment of the patient receiving the service.
- If a doctor chooses to use a procedure that is not generally accepted in the medical profession as necessary for the treatment of the patient, then the cost of this procedure cannot be included in the fee for a Medicare item.
- Any charge for this procedure must be separately listed on the account and not billed to Medicare.

2. *Including an amount for goods supplied for the patient to use at home in the consultation charge (eg. Wheelchairs, oxygen tanks, continence pads).*

- Medicare benefits are paid in respect of specific services provided by a doctor at the time of the consultation.
- The provision of goods, such as wheelchairs and oxygen tanks, for later use is not part of the consultation and cannot be charged to Medicare.
- Charges can be levied for these items but must be separately listed on the account and not billed to Medicare.

3. *Charging part or all of an in-patient procedure to an out-patient consultation.*

- If a doctor charges part or all of an in-hospital procedure to an out-patient consultation, then the account issued by the doctor is not an accurate statement of the services provided and would constitute a false or misleading statement.
- No Medicare benefits would be payable in respect of the services provided.

4. *Re-issuing modified accounts to include other charges and out of pocket expenses not previously included in the account.*

- The account issued to a patient by a doctor must state the amount charged for service provided and truly reflect what occurred between the patient and doctor.
- Re-issuing an account to correct a genuine error is legitimate.
- However, if an account is re-issued to increase the fee or load additional components to the fee, the account is not a true statement of the fee charged for the service and would constitute a false or misleading statement.
- No Medicare benefits would be payable in respect of the services provided.

1.2.4 Consequences of improperly issuing an account

If the fee specified in an account includes components for goods and services that are not part of the specified MBS item, there are two consequences:

1. A Medicare benefit is not payable for the professional service.
2. The doctor who issued the account, or authorised it to be issued, will be guilty of making a false or misleading statement, which is a criminal offence under sections 128A and 128B of the *Health Insurance Act 1973*.
    - Excess Medicare benefits paid as a result of a false or misleading statement are recoverable from the doctor under section 129AC of the *Health Insurance Act 1973.*

1.2.5 Enforcement and recovery action

Medicare Australia has a legal responsibility and power to investigate doctors suspected of making false or misleading statements, and can refer individual doctors for prosecution if there is evidence of fraudulent charging to Medicare.

If Medicare benefits have been paid inappropriately or incorrectly, Medicare Australia will take recovery action.

2. PROVIDER ELIGIBILITY

2.1 Access to Medicare Benefits

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

- the person was a medical practitioner prior to 1 November 1996 (this does not include an intern or Australian Medical Council candidate who has not completed a required period of supervised training, a person without the legal right to be in Australia on 1 November 1996, or a person acting as a medical practitioner on a temporary visa); or
- the person is a recognised specialist, consultant physician or general practitioner; or
- the person is in an approved placement under section 3GA of the Health Insurance Act 1973; or
- the person is a temporary resident doctor with an exemption under section 19AB of the Health Insurance Act 1973, while working in accord with that exemption (Note: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors).

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

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

2.1.4 To be eligible to provide an allied health or dental care service which can attract a Medicare benefit under MBS items 10950-10977, allied health professionals, dentists, and dental specialists must be recognised professionals who are registered under relevant State or Territory law or, where there is no such State or Territory law, practitioners who are members of a professional association with uniform national registration requirements. They must also be registered with Medicare Australia to provide the services.

2.2 Provider Numbers

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

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

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

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

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

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

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

2.2.5 Pay group arrangements are available which allow Medicare benefit cheques, which would normally be payable to a medical practitioner, to be made payable to a third party. Information about pay group links is contained in the provider number application form and is available from Medicare Australia and on their website at www.medicareaustralia.gov.au. Existing pay group arrangements can be terminated by a written request from the practitioner, however, Medicare Australia will routinely inform the payee of such a termination.

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

2.3 Locum Tenens

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

- the practitioner is an RACGP or specialist trainee with a provider number issued for an approved training placement; or
- the practitioner is associated with an approved rural placement under Section 3GA of the Health Insurance Act 1973; or
- the practitioner has access to Medicare benefits as a result of the issue of an exemption under section 19AB of the Health Insurance Act 1973 which only gives the practitioner access to Medicare benefits at specific practice locations; or
- the locum is to provide services at a practice which is participating in the Practice Incentives Program as the use of a provider number not specifically allocated for the practice will affect payments to the practice under the Practice Incentives Program.

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

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

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

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

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

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

2.5 Overseas Trained Doctors and the Ten Year Moratorium

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

- before 1 January 1997, registered with a State or Territory medical board (not including a person on a temporary resident visa) provided that they retained the continuous legal right to remain in Australia; or
- made an application to the Australian Medical Council (AMC) which was received before 1 January 1997, to undertake examinations, successful completion of which would ordinarily enable the person to become a medical practitioner (and was eligible to lodge an application with the AMC).

2.5.2 The Minister can grant an exemption to these requirements and can impose conditions on any exemption provided. Requests for exemption from the restrictions contained in section 19AB should be directed to the Department of Health and Ageing on (02) 6289 5903.

2.6 Overseas Trained Doctors (OTD) and Occupational Trainees (OT)

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

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

2.6.2 Those OTD/OT deemed eligible for a Medicare provider number by the issue of a Section 19AB exemption by the Minister's delegate will need to provide their name and address, as well as their Medicare provider number on all bills for services they have rendered where a Medicare benefit is to be claimed.

2.6.3 The issue of a section 19AB exemption is not automatic and is not backdated. Medicare benefits cannot be paid for services rendered by an OTD/OT until a 19AB exemption has been issued. Delegations for the issue of section 19AB exemptions are held by the Department of Health and Ageing and as a result, applications received by Medicare Australia will be forwarded to the Department for approval. Applicants for section 19AB exemptions should apply to Medicare Australia.

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

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

2.7 Use of Provider Numbers and Closure of Practice Locations

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

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

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

2.8 Practice Incentives Program

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

2.9 Addresses of Medicare Australia

Postal: Medicare, GPO Box 9822, in the Capital City in each State
Telephone: 132150, All States (a local call cost)

NEW SOUTH WALES	VICTORIA	QUEENSLAND
The Colonial State Bank Tower 150 George Street PARRAMATTA NSW 2165	State Headquarters 460 Bourke Street MELBOURNE VIC 3000	State Headquarters 444 Queen Street BRISBANE QLD 4000
SOUTH AUSTRALIA	**WESTERN AUSTRALIA**	**TASMANIA**
State Headquarters 209 Greenhill Road EASTWOOD SA 5063	State Headquarters Bank West Tower 108 St. George's Terrace PERTH WA 6000	242 Liverpool Street HOBART TAS 7000
AUSTRALIAN CAPITAL TERRITORY		**NORTHERN TERRITORY**
134 Reed Street TUGGERANONG ACT 2901		As per South Australia

3. PATIENT ELIGIBILITY FOR MEDICARE

3.1 Eligible Persons

3.1.1 An "eligible person" means a person who resides legally in Australia and whose stay is not subject to any time limitation. This includes New Zealand citizens resident in Australia and holders of permanent residence visas. Applicants for permanent residence are eligible persons in certain circumstances.

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

3.2 Medicare Cards

3.2.1 An eligible person who applies to enrol in Medicare (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare Card (green in colour). Cards may be issued for individuals or families.

3.2.2 Medicare cards (blue in colour), with the words "INTERIM CARD" are issued in certain circumstances to persons who have applied for permanent resident status.

3.2.3 Medicare cards with the words " VISITOR RHCA" are issued to visitors from countries with which Australia has Reciprocal Health Care Agreements (see section 3.5 below).

3.3 Health Care Expenses Incurred Overseas

3.3.1 Medicare does **NOT** cover medical, hospital or evacuation expenses incurred outside Australia. Australians travelling overseas are advised to have adequate private health insurance for the countries to be visited (see also section 3.5 below).

3.4 Visitors to Australia and Temporary Residents

3.4.1 Visitors and temporary residents in Australia are not eligible for Medicare, unless covered by a Reciprocal Health Care Agreement, and should have adequate private health insurance.

3.4.2 All eligible visitors must enrol with Medicare to receive benefits. The period of eligibility is shown by the expiry date on the Medicare card.

3.5 Reciprocal Health Care Agreements

3.5.1 Visitors from countries with which Australia has Reciprocal Health Care Agreements are eligible for immediately necessary treatment in the public health system. Likewise, Australians visiting these countries are entitled to health care in their public health schemes. Agreements are in place with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Italy, Norway and Malta. Visitors are eligible for benefits for the duration of their stay, except in the cases of Italy and Malta, where benefits are for six months only. With the exception of New Zealand, the Agreements provide diplomats and their families with full Medicare cover for the term of their stay, which is not restricted to immediately necessary treatment.

3.5.2 The Agreements provide immediately necessary treatment, that is, treatment for any ill health or injury which requires attention before returning home. They provide public hospital care, Medicare benefits and drugs under the Pharmaceutical Benefits Scheme.

3.5.3 The Agreements with Ireland and New Zealand are restricted to public hospital care and PBS drugs only. Visitors receive services by presenting their passports. They are not issued with Medicare cards.

3.5.4 The Agreements do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving health treatment are not eligible for benefits in the Agreement.

4. GENERAL PRACTICE

4.1 General Practice Items

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

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

4.2 Fellows of the RACGP and Trainees in General Practice

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

4.3 Vocational Registration of General Practitioners

Recognition Method

4.3.1 The criteria for registration as a vocationally registered general practitioner are certification from either:-

- the Royal Australian College of General Practitioners (RACGP); or
- a General Practice Recognition Eligibility Committee (GPREC); or
- the General Practice Recognition Appeal Committee (GPRAC),

that the practitioner's medical practice is or will be within 28 days predominantly general practice, and

- that the RACGP or the Eligibility Committee certifies that the practitioner is a Fellow of the RACGP; and
- the RACGP certifies that the practitioner meets its minimum requirements for taking part in continuing medical education and quality assurance programs.

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

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

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

4.3.5 All enquiries concerning eligibility for registration should be directed to the Program Relations Officer, RACGP, College House, 1 Palmerston Crescent, South Melbourne, VIC, 3205 or to the GPREC, Medicare Australia, PO Box 1001, Tuggeranong, ACT 2901.

How to Apply for Registration

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

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

Chief Executive Officer
The Royal Australian College of General Practitioners
College House
1 Palmerston Crescent
SOUTH MELBOURNE VIC 3205

Secretary
General Practice Recognition Eligibility Committee
Medicare Australia
PO Box 1001
TUGGERANONG ACT 2901

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

4.3.9 All enquiries regarding the QA and CME requirements should be directed to the Program Relations Officer, RACGP, College House, 1 Palmerston Crescent, South Melbourne, VIC, 3205

Removal from Vocational Register

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

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

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

4.3.12 Appeals against removal may be made to the GPRAC, at Medicare Australia, PO Box 1001, Tuggeranong, ACT, 2901.

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

5. RECOGNITION AS A SPECIALIST OR CONSULTANT PHYSICIAN

5.1 Recognition Method

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

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

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

5.1.2 A medical practitioner who:-

- is training towards a fellowship of a specified specialist College;

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

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

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

5.1.5 All enquiries concerning the recognition of specialists and consultant physicians or specialist and consultant physician trainees should be directed to the Provider Liaison Section, Medicare Australia, PO Box 9822 in your State capital city. ACT and NT enquiries should be directed to NSW. Telephone enquiries can be directed to 132 150 for the cost of a local call.

5.2 Emergency Medicine

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

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

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

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

6. REFERRAL OF PATIENTS TO SPECIALISTS OR CONSULTANT PHYSICIANS

6.1 Purpose

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

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

6.2 What is a Referral

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

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

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

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

(a) sub-paragraphs (i), (ii) and (iii) do not apply to:
. an examination of a patient by a specialist anaesthetist in preparation for the administration of an anaesthetic (Item 17603);

(b) sub-paragraphs (ii) and (iii) do not apply to:
. a referral generated within a hospital, in respect of a privately admitted patient for a service within that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
. an emergency situation where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

(c) sub-paragraph (iii) does not apply to:
. instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

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

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

6.3 Examination by Specialist Anaesthetists

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

6.4 Who can Refer

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

6.4.2 Referrals are to be made as follows:-

(a) to a recognised consultant physician -

(i) by another medical practitioner; or

(ii) by an approved dental practitioner[1] (oral surgeon), where the referral arises out of a dental service;

(b) to a recognised specialist -

(i) by another medical practitioner; or

(ii) by a registered dental practitioner [2], where the referral arises out of a dental service; or

(iii) by a registered optometrist where the specialist is an ophthalmologist.

[1] See paragraph OB.1 for the definition of an approved dental practitioner.

[2] A registered dental practitioner is a dentist registered with the State or Territory Dental Board of the State or Territory in which s/he practices. A registered dental practitioner may or may not be an approved dental practitioner.

6.5 Billing

Routine Referrals

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

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

Special Circumstances

6.5.2 (i) Lost, stolen or destroyed referrals.

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

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

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

(iii) Hospital referrals.

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

• Public Hospital Patients - Under the 2003-2008 Australian Health Care Agreements, hospitals are obliged to provide public hospital services to eligible persons in accordance with the provisions of the Agreements.

Bulk Billing

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

6.6 Period for which Referral is Valid

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

Specialist Referrals

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

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

Referrals by other Practitioners

6.6.4 Where the referral originates from a practitioner other than those listed in 6.6.2, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

6.7 Definition of a Single Course of Treatment

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

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

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

6.7.4 However, where the referring practitioner:-

(a) deems it necessary for the patient's condition to be reviewed; and

(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and

(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

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

6.8 Retention of Referral Letters

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

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

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

6.9 Attendance for Issuing of a Referral

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

6.10 Locum-tenens Arrangements

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

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

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

6.11 Self Referral

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

6.12 Referrals by Dentists or Optometrists

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

(i) a recognised specialist:

(a) by a registered dental practitioner, where the referral arises out of a dental service; or

(b) by a registered optometrist where the specialist is an ophthalmologist; or

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

6.12.2 In any other circumstances (ie a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is not a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

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

7. BILLING PROCEDURES

NOTE: Important information about Medicare benefits and billing procedures has been included under Section 1 of these Notes – practitioners are advised to make themselves aware of this information.

7.1 Itemised Accounts

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

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

(i) patient's name;

(ii) the date on which the professional service was rendered;

(iii) the amount charged in respect of the service;

(iv) the total amount paid in respect of the service;

(v) any amount outstanding in respect of the service;

(vi) a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment (ie accommodation and nursing care) is provided in a hospital or day hospital facility (other than a public hospital patient), that is, the words 'admitted patient' immediately preceding the description of the service or an asterisk '*' directly after an item number where used;

(vii) the name and practice address or name and provider number of the practitioner who actually rendered the service; (where the practitioner has more than one practice location recorded with Medicare Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given);

(viii) the name and practice address or name and provider number of the practitioner claiming or receiving payment of benefits, or assignment of benefit:-

- for services in Groups A1 to A14, D1, T1, T4 to T9 of the General Medical Services, Groups O1 to O7 (Oral and Maxillofacial services), and Group P9 of Pathology - where the person claiming payment is NOT the person who rendered the service;
- for services in Groups D2, T2, T3, I2, to I5 - for every service;

(ix) if the service was a Specified Simple Basic Pathology Test (listed in Category 6 - Pathology, Group P9 of the Schedule) that was determined necessary by a practitioner who is another member of the same group medical practice, the surname and initials of that other practitioner;

(x) where a practitioner has attended the patient on more than one occasion on the same day and on each occasion rendered a professional service to which an item in Category 1 of the Medicare Benefits Schedule relates (ie professional attendances), the time at which each such attendance commenced; and

(xi) where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred:- (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number in respect of that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

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

7.1.3 Practitioners should note that payment of claims could be delayed or disallowed where it is not possible from account details to clearly identify the service as one which qualifies for Medicare benefits, or the practitioner as a registered medical

practitioner at the address the service was rendered. Practitioners are therefore encouraged to provide as much detail as possible on their accounts, including Medicare Benefits Schedule item number and provider number.

7.2 Claiming of Benefits

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

7.3 Paid Accounts

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

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

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

7.3.4 Alternatively a patient may lodge their claim electronically from the doctors' surgery using Medicare Australia's Online claiming.

7.4 Unpaid and Partially Paid Accounts

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

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

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

7.4.4 Where a patient has reached the relevant extended Medicare safety net threshold, the Medicare benefit payable is the Medicare rebate for the service plus 80% of the out-of-pocket cost of the service (ie difference between the fee charged by the doctor and the Medicare rebate). The patient must pay at least 20% of the out-of-pocket cost of the account before extended Medicare safety net benefits become payable for the out-of-pocket cost. Medicare will apportion the benefit accordingly.

7.5 Assignment of Benefit (Direct – Billing) Arrangements

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

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

7.5.3 Under these arrangements:-

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

7.5.4 Where the patient is direct-billed, an additional charge can **ONLY** be raised against the patient by the practitioner where the patient is provided with a vaccine/vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items 3 to 96, 5000 to 5267 (inclusive) and item 10993 and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme.

The additional charge must only be to cover the supply of the vaccine.

7.6 Use of Medicare Cards in Direct Billing

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

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

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

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

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

7.7 Assignment of Benefit Forms

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

(1) Form DB2-GP. This form is designed for the use of optical scanning equipment and is used to assign benefits for General Practitioner Services other than requested pathology, specialist and optometrical services. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy. There are 4 pre-printed items with provision for two other items. The form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.

(2) Form DB2-OP. This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. This form may not be used as an offer to assign pathology services.

(3) Form DB2-OT. This form is designed for the use of optical scanning equipment and is used to assign benefits for all specialist services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. There are no pre-printed items on this form.

(4) Form DB3. This is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.

(5) Form DB4. This is a continuous stationery version of the DB2, and has been designed for use on most office accounting machines.

(6) Form DB5. This is a continuous stationery form for pathology services which can be used on most office machines. It cannot be used to assign benefits and must therefore be accompanied by an offer to assign (Form DB2, DB3 or DB4) or other form approved by Medicare Australia for that purpose.

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

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

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

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

7.9 Direct-Bill Stationery

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

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

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

7.10 Time Limits Applicable to Lodgement of Claims for Assigned Benefits

7.10.1 A time limit of six months applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.
7.10.2 Provision exists whereby in certain circumstances (eg hardship cases, third party workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

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

Doctors

8.1 Professional Services Review (PSR) Scheme

8.1.1 The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). A health practitioner is a medical practitioner, a dentist, an optometrist, a chiropractor, physiotherapist or a podiatrist.
8.1.2 Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services.
8.1.3 Medicare Australia monitors health practitioners claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, Medicare Australia can request that the Director of PSR review the provision of services by the practitioner.
8.1.4. From 1 January 2003, several changes were introduced to clarify each stage in the PSR process, and to strengthen the procedural fairness provisions available to the person under review.
8.1.5 Under the revised PSR arrangements, the decision to establish a PSR Committee is made by the independent Director of PSR after receiving a request from Medicare Australia for a review of the provision of services by a person (previously this was an investigative referral).
8.1.6 When a request for a review is made, the Director of PSR must decide whether to conduct a review. If a review is carried out into the provision of services specified in the referral, it can be done in such manner, as the Director thinks appropriate. The Director has the power to require the production of documents or the giving of information.
8.1.7. Following a review, the Director must:

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

8.1.8. A PSR Committee will normally consist of three medically qualified members of whom two must belong to the same profession as the practitioner whose conduct is the subject of review. However, if considered desirable, up to two additional members may be appointed to a Committee to give it a wider range of clinical expertise.
8.1.9 A referral to a PSR Committee (previously this was an adjudicative referral) initiates an investigation by the Committee into the provision of the services specified in the referral. The Committee can investigate any aspect of the provision of the referred services and its investigation is not limited by any reasons given in a request for review or a Director's report following a review.
8.1.10. Committees can hold hearings and require the person under review to attend and give evidence. Committees also have the power to require the production of documents (including clinical notes).
8.1.11. The various methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation.

- Patterns of Services - Where a practitioner reaches or exceeds a volume of services specified in regulations, he or she is deemed to have practised inappropriately. From 1 January 2000, the pattern of services for general practitioners and other medical practitioners specified in *the Health Insurance Regulations 1999 (No. 1),* as amended, is 80 or more professional attendances on each of 20 or more days in a 12-month period.
- A professional attendance includes a service of a kind mentioned in group A1, A2, A5, A6, A7, A11, A13, A14 or A15 of Part 3 of the General Medical Services Table.

- Where a practitioner can demonstrate to the satisfaction of a PSR Committee that exceptional circumstances exist, the quantum of inappropriate practice is reduced accordingly. Matters that constitute exceptional circumstances include, but are not limited to, those set out in the Regulations. These include:

    : an unusual occurrence causing an unusual level of need for professional attendances by the practitioner; and
    : the absence of other medical services for the practitioner's patients (having regard to the location of the practice and the characteristics of the patients).

- Sampling - A PSR Committee can apply a statistically valid sampling methodology to examine the conduct of a practitioner in relation to particular identifiable services and to extrapolate the results to a larger number of similar services within the referral period.
- Generic findings - If a PSR Committee cannot conduct its inquiry using the patterns of services or sampling provisions, it can make a generic finding of inappropriate practice. This will apply where a PSR Committee is unable to obtain sufficient clinical or practice records from the practitioner to conduct its investigation.

8.1.12 In determining whether a practitioner has engaged in inappropriate practice, from 1 November 1999 a PSR Committee is also required to have regard to whether or not the practitioner kept adequate and contemporaneous patient records (see details at Note 15.).
8.1.13 Provision is made throughout the Scheme for the person under review to make submissions before key decisions are made or final reports are given.
8.1.14 Under the revised arrangements, a Committee cannot make a finding of inappropriate practice unless it has given the person under review: notice of its intention to do so; and the reasons for the findings; and an opportunity to respond.
8.1.15. If a Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority. The Determining Authority decides what action to take. Such action can include: a reprimand; counselling; repayment of Medicare benefits; and/or complete or partial disqualification from the Medicare Scheme for up to three years.
8.1.16 The revised PSR arrangements apply in relation to requests by the HIC to the Director of PSR made after 1 January 2003. Existing cases will be dealt with under the previous arrangements.
8.1.17 Further information is available from the PSR website, www.psr.gov.au.

8.2 Medicare Participation Review Committee (MPRC)
8.2.1 The Medicare Participation Review Committee determine what administrative action should be taken against a practitioner who has been successfully prosecuted for medifraud.
8.2.2 The Committees have a discretionary range of options from taking no further administrative action against the practitioner to counselling and reprimand and full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

Schedule Services

8.3 Medicare Benefits Consultative Committee (MBCC)
8.3.1 The MBCC is an informal advisory committee established by agreement between the Minister and the Australian Medical Association. The Committee consists of representatives of the Department, Medicare Australia, the Australian Medical Association and relevant craft groups of the medical profession.
8.3.2 The major function undertaken by the Committee is the review of particular services or groups of services within the Medicare Benefits Schedule, including consideration of appropriate fee levels.

8.4 Medical Services Advisory Committee (MSAC)
8.4.1 The Medical Services Advisory Committee was established in April 1998 to advise the Minister on the strength of evidence relating to the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the Medicare Benefits Schedule, should be supported.
8.4.2 Its membership comprises a mix of clinical expertise covering pathology, surgery, internal medicine and general practice, plus clinical epidemiology and clinical trials, health economics, consumers, and health administration and planning.
8.4.3 The assessment of evidence has been an integral part of the listing process of medical technologies and services on the Schedule via a mix of specialist consultative and advisory bodies. This measure will strengthen and consolidate the assessment activity under the umbrella of MSAC and will complement the functions and activities of the Medicare Benefits Consultative Committee, Pathology Services Table Committee and the Consultative Committee on Diagnostic Imaging.
8.4.4 Since its establishment MSAC has been developing application and assessment guidelines to assist it to meet its terms of reference. Further information on MSAC's terms of reference, membership, and application and assessment processes and related activities can be found at its internet site www.health.gov.au/msac/index.htm
8.4.5 Contact with MSAC can be made via email on **msac.secretariat@health.gov.au** or by phoning the MSAC secretariat on 1800 020 103**.**

8.5 Pathology Services Table Committee (PSTC)

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

8.5.2 The Committee's primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table (except new medical services and technologies - see paragraph 8.4 above) including the level of fees.

8.6 Review of Claims Requiring Prior Approval for Payment of Benefits

8.6.1 There are a number of items in the Schedule which contain a requirement that it must be 'demonstrated' that there is a clinical need for the service before Medicare benefits are payable. Services requiring prior approval are those covered by items 11222/11225, 12207, 12215, 12217, 14124, 21965, 21997, 30214, 32501, 42771, 42783, 42786, 42789, 42792, 45019/45020, 45528, 45557, 45558, 45585, 45586, 45588, 45639, 50125 and 55728.

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

8.6.3 Practitioners may also apply to Medicare Australia for prospective approval in respect of proposed surgery.

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

9. PENALTIES AND LIABILITIES

9.1 Penalties

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

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

GENERAL NOTES FOR GUIDANCE OF USERS

10. SCHEDULE FEES AND MEDICARE BENEFITS

10.1 Schedule Fees and Medicare Benefits

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

10.1.2 As a general rule Schedule fees are adjusted on an annual basis. The current Schedule fees came into operation on 1 November 2004.

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

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

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

(ii) for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse on behalf of a general practitioner, the Medicare benefit is 100% of the Schedule fee.

(iii) for all other professional services, the Medicare benefit is 85% of the Schedule fee, or the Schedule fee less $60.00 (indexed annually) whichever is the greater.

10.1.4 Public hospital services are available free of charge to eligible persons who choose to be treated as public patients, in accordance with the provisions of the 2003-2008 Australian Health Care Agreements.

10.1.5 A medical service rendered to a patient on the day of admission to, or day of discharge from hospital, but prior to admission or subsequent to discharge, will attract benefits at the 85% or 100% level not 75%. This also applies to a pathology service rendered to a patient prior to admission. Attendances on patients at a hospital (other than patients covered by paragraph 10.1.3 (i) above) attract benefits at the 85% level.
10.1.6 The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.
10.1.7 Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits.
10.1.8 It should be noted that the Health Insurance Act makes provision for private medical insurance to cover the "patient gap" (i.e., the difference between the Medicare rebate and the Schedule fee) for services attracting benefits at the 75% level. Patient's may insure with private health insurance organisations for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an arrangement with their health fund.
10.1.9 Where it can be established that payments of $328.00 (indexed annually from 1 January) have been made by a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee for out-of-hospital services, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee.

11. SERVICES NOT LISTED IN THE SCHEDULE

11.1 Services not Listed in Schedule

11.1.1 Benefits are not generally payable for services not listed in the Schedule. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. Such services would include intramuscular injections, aspiration needle biopsy, treatment of sebhorreic keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe). Further services for which benefits are payable on a consultation basis are identified in the indexes to this book.
11.1.2 Enquiries concerning services not listed or on matters of interpretation should be directed to the appropriate office of Medicare Australia. Postal addresses are listed in paragraph 2.9 of these notes. Telephone enquiries should be directed to the numbers below which are reserved for enquiries concerning the Schedule:

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

11.2 Ministerial Determinations

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

12. SERVICES ATTRACTING MEDICARE BENEFITS

12.1 Professional Services

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

(a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11601, 11627, 11701, 11712, 11724, 11921, 12000, 12003;
(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218 and 14221);
(d) Item 15600 in Group T2 (Radiation Oncology);

(e) All Group T3 (Therapeutic Nuclear Medicine) items;
(f) All Group T4 (Obstetrics) items (except 16514);
(g) All Group T6 (Anaesthetics) items;
(h) All Group T7 (Regional or Field Nerve Block) items;
(i) All Group T8 (Operations) items;
(j) All Group T9 (Assistance at Operations) items;
(k) All Group T10 (Relative Value Guide for Anaesthetics) items.

12.1.3 For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, benefits are payable only if the services have been conducted personally by the medical practitioner.
12.1.4 Medicare benefits are not payable for these group items or any of the items listed in (a)-(k) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital, not being a private hospital, other than when the practitioner is exercising his or her right of private practice or is performing a medical service outside the hospital. For example, benefits are not attracted when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

12.2 Services Rendered "On Behalf Of" Medical Practitioners
12.2.1 Medical services in Categories 2 and 3 not included in the above list and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-
(i) a medical practitioner;
(ii) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.
(see Category 6 Notes for Guidance for arrangements relating to Pathology services).
12.2.2 In order that a service rendered by an employee or under the supervision of a medical practitioner can attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. Medicare Australia would need to be satisfied with the employment and supervision arrangements. In this regard, while the supervising medical practitioner need not be present for the entire service, he or she must have a direct involvement in at least part of the service. Although the supervision requirements would vary depending on the test or examination being performed, they would, as a general rule, be satisfied where the medical practitioner has:-
(i) established consistent quality assurance procedures for the data acquisition; and
(ii) personally analysed the data and written the report.
12.2.3 Benefits are not payable for these services when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.
12.2.4 Services in Category 8, Group M2 (Services provided by a practice nurse on behalf of a medical practitioner) are provided under the supervision of a general practitioner (GP) and the GP retains responsibility for the health, safety and clinical outcomes of the patient. This does not mean that the GP has to be present while the practice nurse is providing the service. (Refer to Explanatory Notes M.2)

13. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

13.1 Services Not Attracting Benefits
13.1.1 Medicare benefits are not payable for telephone consultations, for the issue of repeat prescriptions when the patient is not in attendance, and for group attendances (other than group attendances covered by Items 170, 171, 172, 342, 344 and 346) such as counselling, health education, weight reduction or fitness.
13.1.2 There are other services which are not regarded as being 'medical services' for the purposes of the payment of Medicare benefits. Services performed for cosmetic reasons, such as face lifts, eye-lid reduction, hair transplants (except in certain circumstances), etc do not attract benefits. Certain other services such as manipulations performed by physiotherapists do not qualify for Medicare benefit even though they may be done on the advice of a medical practitioner.
13.1.3 Medicare benefits are not payable for the performance of euthanasia, including any service directly related to the procedure. However, services rendered for counselling/assessment in relation to euthanasia would attract benefits.

13.2 Where Medicare Benefits are not Payable
13.2.1 Medicare benefits are not payable in respect of a professional service in the following circumstances:-
(a) where the medical expenses for the service are paid or payable to a recognised (public) hospital;
(b) where the medical expenses for the services are in relation to a compensable injury or illness for which the patient's insurer or compensation payer has accepted liability. However, if medical expenses relate to a compensable injury or illness and the insurer or compensation payer is disputing liability, Medicare benefits are payable until liability is accepted;
(c) where the service is a medical examination for the purposes of - life insurance, superannuation or provident account scheme, or admission to membership of a friendly society;
(d) where the service was rendered in the course of the carrying out of mass immunisation.
13.2.2 Unless the Minister otherwise directs, Medicare benefits are not payable in respect of a professional service where:-

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

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

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

13.3 Health Screening Services

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

13.3.2 A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as - multiphasic health screening; mammography screening (except as provided for in Items 59300/59303); testing of fitness to undergo physical training programs, vocational activities or weight reduction programs; compulsory examinations and tests to obtain a flying, commercial driving or other licence, entrance to schools and other educational facilities, for travel requirements and for the purposes of legal proceedings; compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

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

- a medical examination or a test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain his/her state of health. In such cases benefits would be payable for the attendance and such tests which would be considered reasonably necessary according to the circumstances of the patient such as age, physical condition, past personal and family history. Examples would be Papanicolaou test in a woman (see para. 13.3.4), blood lipid estimation where a person has a family history of lipid disorder. However, it would not be accepted that a routine check up would necessarily be accompanied by an extensive battery of diagnostic investigations;
- a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- medical examinations for reason of age or medical condition, for drivers to obtain or renew a licence to drive a private motor vehicle;
- medical examinations to obtain a certificate of hearing disability required for sales tax exemption for a television decoding device;
- a medical or optometrical examination provided to a person who is an unemployed person for the purposes of the Social Security Act 1991, at the request of a person to whom the unemployed person has applied for employment;
- a medical examination of, and/or the collection of blood for testing from, persons occupationally exposed to sexual transmission of disease where the purpose of such an examination or collection is the collection of specimens for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed, (1 examination/collection per person per week). Benefits are not attracted in respect of pathology tests resulting from such examination/collection;
- a medical examination to adopt or foster children;
- a medical examination which is required to claim eligibility for certain Social Security benefits or allowances.

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

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

Note 1: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph PP.3 of Pathology Services Explanatory Notes in Category 6).
Note 2: See items 2501, 2503, 2504, 2506, 2507, 2509, and 2600, 2603, 2606, 2610, 2613 and 2616 in Group A18 and A19 of Category 1 – Professional Attendances and A.27 in the explanatory notes for Category 1 – Professional Attendances.

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

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

14. INTERPRETATION OF THE SCHEDULE - GENERAL NOTES

14.1 Principles of Interpretation

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

14.2 Services Attracting Benefits on an Attendance Basis

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

14.3 Consultation and Procedures Rendered at the One Attendance

14.3.1 Where there are rendered, during the course of a single attendance, a consultation (under Category 1 of the Medicare Benefits Schedule) and another medical service (under any other Category of the Schedule), benefits are payable subject to certain exceptions, for both the consultation and the other service. Medicare benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item description is qualified by words such as "each attendance", "attendance at which", “including associated attendances/consultations", and all items in Group T6 and T9. However, in the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.
14.3.2 In cases where the level of benefit for an attendance depends upon consultation time (eg attendance by consultant physicians in psychiatry), the time spent in carrying out a procedure, which is covered by another item in the Schedule, must not be included in the consultation time.
14.3.3 Medical practitioners should ensure that a fee for a consultation is charged only when a consultation actually takes place. It is not expected that a consultation fee will be charged on every occasion a procedure is performed.

14.4 Aggregate Items

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

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

14.5 Residential Aged Care Facility

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

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

15.1 Requirements

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

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

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

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

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

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

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

GENERAL MEDICAL SERVICES

CATEGORIES 1, 2, 3 and 8

PROFESSIONAL ATTENDANCES

CATEGORY 1

CATEGORY 1 - PROFESSIONAL ATTENDANCES

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CATEGORY 1 - PROFESSIONAL ATTENDANCES

EXPLANATORY NOTES

A.1 Personal Attendance by Practitioner

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

A.2 Professional Attendances

A2.1 Professional attendances by medical practitioners cover consultations during which the practitioner evaluates the patient's problem (which may include certain health screening services - see paragraph 13.3 of the General Explanatory Notes) and formulates a management plan, in relation to one or more conditions present in the patient. The service also includes advice to the patient and/or relatives and the recording of appropriate detail of the particular services - (see also paragraphs A.5.6 - A.5.7)

A.3 Services Not Attracting Medicare Benefits

A.3.1 Telephone consultations, letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death certificates (see Note A3.2), cremation certificates, counselling of relatives (Note - items 348, 350 and 352 are not counselling services), group attendances (other than group attendances covered by items 170, 171, 172, 342, 344 and 346) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

A3.2 Although Medicare benefits are not payable for the issue of a death certificate, an attendance on a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item. The outcome of the attendance may be that a death certificate is issued, however, Medicare benefits are only payable for the attendance component of the service.

A.4 Multiple Attendances on the Same Day

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

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

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

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

A.5 Attendances by General Practitioners (Items 1-51, 193, 195, 197, 199, 601, 602, 2501-2559, 5000-5067)

A.5.1 Items 1 to 51 and 193, 195, 197, 199, 601, 602, 2501-2559, 5000-5067 relate specifically to attendances rendered by medical practitioners who are either:

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

Only general practitioners are eligible to itemise these content-based items. (See paragraphs 4.1, 4.2 and 4.3 of the General Explanatory Notes in the 1 November 2004 MBS Book for details of eligibility and registration.)

A.5.2 Items 1 to 51 and 5000 to 5067 cover four categories of general practitioner attendance based largely on the tasks undertaken by the practitioner during the attendance on the patient rather than simply on the time spent with the patient.

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

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

LEVEL A
These items are for the obvious and straightforward cases and the practitioner's records would reflect this. In this context 'limited examination' means examination of the affected part if required, and 'management' the action taken.
Example: Triple Antigen or Tetanus Immunisation

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

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

LEVEL D
These items cover the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they should be performed. These items also cover cases which need prolonged discussion. Physical attendance of at least 40 minutes is necessary to qualify for a Level D attendance.
Examples: Migraine with peripheral neurological signs
Depression presenting as insomnia or headaches
Complex psychological or family relationship problems

Counselling or Advice to Patients or Relatives
A.5.5 For items 23 to 51 and 5020 to 5067 'implementation of a management plan' includes counselling services.
A.5.6 Items 1 to 51 and 5000 to 5067 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

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

Other Services at the Time of Attendance
A.5.8 Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see paragraph 14.3 of the General Explanatory Notes in the 1 November 2004 MBS Book for further details).

After-Hours Attendances (Items 5000 - 5067 and 5200 - 5267)
A.5.9 There are attendance items (5000 - 5067 and 5200 - 5267) for medical services that are rendered after-hours. These items apply to GP and other non-referred attendances provided after-hours in a consulting room, residential aged care facility, institution or home.
A.5.10 An after-hours attendance or visit is a reference to a consultation provided on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a weekday not being a public holiday. In order to claim items 5000 - 5067 and 5200 - 5267, the professional attendance itself must begin in an after-hours period regardless of when the appointment was made.
A. 5.11 Where a practice or clinic routinely conducts its business during an after-hours period as quoted above, the medical practitioner would only use the after-hours attendance items (items 5000 - 5067 and 5200 - 5267) and not the emergency after-hours items (1, 2, 97, 98, 448, 449, 601, 602, 697, 698).

Locum-Tenens

A.5.12 Where a general practitioner engages, either as an assistant or as a locum tenens, a medical practitioner who is not a general practitioner, Medicare benefits in respect of attendances rendered by the latter are attracted under items 52 - 96 and 5200 - 5267 and not under items 1 - 51 and 5000 - 5067.

A.6 Professional Attendances at an Institution (Items 13, 25, 38, 48, 81, 83, 84, 86, 5007, 5026, 5046, 5064, 5240, 5243, 5247, 5248)

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

(a) disadvantaged children;
(b) juvenile offenders;
(c) aged persons;
(d) chronically ill psychiatric patients;
(e) homeless persons;
(f) unemployed persons;
(g) persons suffering from alcoholism;
(h) persons addicted to drugs; or
(i) physically or intellectually disabled persons.

Note: See also paragraph A.9

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

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

Note: See also paragraph A.9

A.8 Residential Aged Care Facility Attendances (Items 20, 35, 43, 51, 92, 93, 95, 96, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267)

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

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

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

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

Note: See also paragraph A.9

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

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

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

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

A.10.1 In addition to the after-hours attendance items, there are emergency after-hours items (1, 2, 97, 98, 448, 449, 601, 602, 697, 698). These emergency after-hours items should only be used in the following instances:

- the consultation is initiated by or on behalf of the patient in the same unbroken after-hours period (on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a weekday not being a public holiday);
- the patient's medical condition must require immediate treatment; and
- if more than one patient is seen on the one occasion, items 1, 2, 97, 98, 448, 449, 601, 602, 697, 698 can be used but only in respect of the first patient. The normal after-hours attendance items for that particular location should be used in respect of the second and subsequent patients attended on the same occasion.

Where the patient is seen at a public hospital the following additional provisions would apply in relation to items 1, 97, 601 and 697:

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

Where any of the above conditions do not apply the after-hours attendance items or the normal attendance items should be used.

A.10.2 Items 2, 98, 448, 449, 602 and 698 are intended to allow benefit for returning to and specially opening up consulting rooms to attend a patient who needs immediate treatment after-hours. As the extra benefit is for the inconvenience of actually returning to and opening the surgery it is payable only once on any one occasion – to the first patient seen after opening up. If other patients are seen on the same occasion, they are itemised as ordinary after-hours surgery attendance (items 5000 - 5067 and 5200 - 5267). In this respect, items 2, 98, 602 and 698 are the same as items 1, 97, 601 and 697.

A.10.3 Items 449, 601, 602, 697 698 are intended to allow benefit for emergency attendances in the 'unsociable hours', that is, 11pm - 7am on any day of the week. Apart from the time restriction, the conditions applying to items 601 and 697 are the same as those applying to items 1 and 97, and the conditions applying to items 449, 602 and 698 are the same as those applying to items 2, 98 and 448.

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

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

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

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

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

(i) the patient must be in imminent danger of death;

(ii) the constant presence of the medical practitioner must be necessary for the treatment to be maintained; and

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

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

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

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

A.14.1 The service of "acupuncture" must be performed by a medical practitioner and itemised under item 173, 193, 195, 197 or 199 to attract benefits. These items cover not only the performance of the acupuncture but include any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given. items 193, 195, 197 and 199 may only be performed by a general practitioner, (see Note 4 of 'Medicare Benefit Arrangements' for a definition) who has been accredited by the Australian Medical Acupuncture College (AMAC) and the RACGP Joint Medical Acupuncture Working Party and must participate in ongoing Quality Assurance (QA) and Continuing Professional Development (CDP) requirements to maintain eligibility.

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

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

A.15 Referred Patient Assessment and Management Plan (Items 291 to 293)

A.15.1 Referral for items 291 to 293 should be through the general practitioner for the management of patients with mental illness. In the event that a specialist of another discipline wishes to refer a patient for this item the referral should take place through the GP.

A.15.2 In order to facilitate ongoing patient focussed management, an outcome tool will be utilised during the assessment and review stage of treatment, where clinically appropriate. The choice of outcome tools to be used is at the clinical discretion of the practitioner, however the following outcome tools are recommended:

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

A.15.3 Preparation of the management plan should be in consultation with the patient. If appropriate, a written copy of the management plan should be provided to the patient. A written copy of the management plan should be provided to the general

practitioner within a maximum of two weeks of the assessment. It should be noted that two weeks is the outer limit and in more serious cases more prompt provision of the plan and verbal communication with the GP may be appropriate. A guide to the content of the report which should be provided to the GP under this item is included within this Schedule.
A.15.4 It is expected that item 291 will be a single attendance. In some circumstances a consultation with the patient may be required before undertaking item 291. In these circumstances a claim would be made under items 300-308.
A.15.5 Item 293 is available in instances where the GP initiates a review of the plan provided under item 291, usually where the current plan is not achieving the anticipated outcome. It is expected that when a plan is reviewed, any modifications necessary will be made.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines

(Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs. An electronic version of the Guidelines is available on the RANZCP website at www.ranzcp.org.au

REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN

Preliminary

- The following content outline is indicative of what would usually be sent back to GPs.
- The Management plan should address the specific questions and issues raised by the GP.
- In most cases the patient is usually well known by the GP.

History and Examination

This should focus on the presenting symptoms and current difficulties, including precipitating and ongoing stresses; and only briefly mention any relevant aspects of the patient's family history, developmental history, personality features, past psychiatric history and past medical history.
It should contain a comprehensive relevant Mental Status Examination and any relevant pathology results if performed.
It should summarise any psychological tests that were performed as part of the assessment.

Diagnosis

A diagnosis should be made either using ICD 10 or DSM IV classification.

In some cases the diagnosis may differ from that stated by the GP, and an explanation of why the diagnosis differs should be included.

Psychiatric formulation

A brief integrated psychiatric formulation focussing on the biological, psychological and physical factors. Any precipitant and maintaining factors should be identified including relevant personality factors. Protective factors should also be noted. Issues of risk to the patient or others should be highlighted.

Management plan

1. ***Education***
   Include a list of any handout material available to help people understand the nature of the problem. This includes recommending the relevant RANZCP consumer and carer clinical practice guidelines.

2. ***Medication recommendations***
   Give recommendations for immediate management including the alternatives or options. This should include doses, expected response times, adverse effects and interactions, and a warning of any contra-indicated therapies.

3. ***Psychotherapy***
   Recommendations should be given on the most appropriate mode of psychotherapy required, such as supportive psychotherapy, cognitive and behavioural psychotherapy, family or relationship therapy or intensive explorative psychotherapy. This should include recommendations on who should provide this therapy.

4. ***Social measures***
   Identify issues which may have triggered or are contributing to the maintenance of the problem in the family, workplace or other social environment which need to be addressed, including suggestions for addressing them.

5. ***Other non medication measures***
   This may include other options such as life style changes including exercise and diet, any rehabilitation recommendations, discussion of any complementary medicines, reading recommendations, relationship with other support services or agencies etc.

6. ***Indications for re-referral***
It is anticipated that the majority of patients will be able to be managed effectively by the GP using the plan. If there are particular concerns about the possible need for further review, these should be noted.

7. ***Longer term management***
Provide a longer term management plan listing alternative measures that might be taken in the future if the clinical situation changes. This might be articulated as a relapse signature and relapse drill, and should include drug doses and other indicated interventions, expected response times, adverse effects and interactions.

A.16 Psychiatric Attendances (Item 319)

A.16.1 Medicare benefits are attracted under Item 319 only where patients are diagnosed as suffering from:

- severe personality disorder (predominantly from cluster B groupings), or in persons under 18 years of age a severe disruption of personality development; or
- anorexia nervosa; or
- bulimia nervosa; or
- dysthymic disorder; or
- substance-related disorder; or
- somatoform disorder; or
- a pervasive developmental disorder (including autism and Asperger's disorder)

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

A.16.2 It is not sufficient for the patient's illness to fall within the diagnostic criteria. It must be evident that a significant level of impairment exists which interferes with the patient's quality of life. For persons 18 years and over, the level of impairment must be within the range 1 to 50 of the Global Assessment of Functioning (GAF) Scale contained in the DSM-IV (ie the patient is displaying at least “serious” symptoms). The GAF score, incorporating the parameters which have led to the score, should be recorded at the time of commencement of the current course of treatment. Once a patient is identified as meeting the criteria of item 319, he/she continues to be eligible under that item for the duration of the current course of treatment (provided that attendances under **items 300 to 308 and 319** do not exceed 160 in a calendar year). Where a patient commences a new course of treatment, the GAF score in relation to item 319 is the patient’s score as assessed during the new course of treatment.

A.16.3 In addition to the above diagnostic criteria and level of functional impairment, it is also expected that other appropriate psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. It is expected that such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long term psychotherapy; pharmacological therapy; cognitive behaviour therapy.

A.16.4 It is the responsibility of the psychiatrist to ensure that the patient meets these criteria. Medicare Australia will be closely monitoring the use of item 319.

A.16.5 When a patient who meets the criteria defined in item 319 attends a psychiatrist on more than 160 occasions in a calendar year, such attendances would be covered by items 310 to 318.

A.16.6 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has undertaken to establish an appropriate mechanism to enable use of item 319 by suitably trained psychiatrists. In the interim it is expected that psychiatrists whose usual practice includes long term intensive treatment of patients whose diagnoses meet the criteria defined in the item will be using item 319.

A.16.7 On the basis of advice from the RANZCP it is expected that it would be generally inappropriate in normal clinical practice for psychiatric treatment performed out of hospital to extend beyond 220 sessions in a calendar year. In this regard, Medicare Australia will be monitoring providers’ practice patterns with a view to the referral of possible cases of inappropriate practice to the Director of Professional Services Review.

A.17 Interview of Person other than a Patient by Consultant Psychiatrist (Items 348, 350, 352)

A.17.1 Items 348 and 350 refer to investigative interviews of a patient's relatives or close associates to determine whether the particular problem with which the patient presented was focused in the patient or in the interaction between the patient and the person being interviewed. These items do not cover counselling of family or friends of the patient. The term "in the course of initial diagnostic evaluation of the patient" should normally be interpreted as extending for up to one month from the date of the initial consultation. There is no strict limit to the number of interviews or persons interviewed in that period. These items should not be used for interviews concerned with the continuing management of the patient. (See para A.17.2)

A.17.2 Item 352 refers to investigative interviews of a patient's relatives or close associates to focus on a particular clinically relevant problem arising in the continuing management of the patient. This item does not cover counselling of family or friends of the patient. The payment of Medicare benefits under this item is limited to four in any twelve month period.

A.17.3 Benefits are payable for Item 348, 350 or 352 and for a consultation with a patient (items 300 - 328) on the same day provided that separate attendances are involved.

A.17.4 For Medicare benefit purposes, charges relating to services covered by items 348, 350 and 352 should be raised against the patient rather than against the person interviewed.

A.18 Consultant Occupational Physician attendances (Items 385 to 388)

A.18.1 Attendances by consultant occupational physicians will attract Medicare benefits only where the attendance relates to one or more of the following:

(i) evaluation and assessment of a patient's rehabilitation requirements where the patient presents with an accepted medical condition(s) which may be affected by his/her working environment or employability; or

(ii) management of accepted medical condition(s) which may affect a patient's capacity for continued employment or return to employment following a non-compensable accident, injury or ill-health; or

(iii) evaluation and opinion and/or management of a patient's medical condition(s) where causation may be related to acute or chronic exposures from scientifically accepted environmental hazards or toxins.

A.19 Contact Lenses (Items 10801-10809)

A.19.1 Benefits are paid for consultations concerned with the prescription and fitting of contact lenses only if patients fall into specified categories (ie patients with certain conditions). The classes of patients eligible for benefits for contact lens consultations are described in items 10801 to 10809. Benefits are not payable for item 10809 in circumstances where patients want contact lenses only for:

(a) reasons of appearance (because they do not want to wear spectacles);

(b) sporting purposes;

(c) work purposes; or

(d) psychological reasons (because they cannot cope with spectacles).

A.19.2 Benefits are payable for an initial referred consultation rendered in association with the fitting and prescribing of the lenses.

A.19.3 Subsequent follow-up attendances attract benefits on a consultation basis.

A.20 Refitting of Contact Lenses (Item 10816)

A.20.1 This item covers the refitting of contact lenses where this becomes necessary within the thirty-six month time limit where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structure or functional change in the eye or an allergic response.

A.21 Health Assessments (Items 700 to 706)

A.21.1 These items do not apply to in-patients of a hospital or day hospital facility or care recipients in residential aged care facilities.

A.21.2 A health assessment should generally only be undertaken by the medical practitioner, or a practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.21.3 The information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the medical practitioner. The other components of the health assessment must include a personal attendance by the medical practitioner.

A.21.4 For the purposes of A21.3, the services of a third party service provider such as a nurse or other assistant may only be used to assist in the information collection component of health assessments where:

(a) use of the third party service provider is initiated by the patient's medical practitioner, after the patient has agreed to a health assessment and to the use of a third party to collect information for the assessment; and

(b) the patient is made aware whether information collected about them for the health assessment will be retained by the third party service provider; and

(c) the third party service provider must act under the supervision of the practitioner. The practitioner should:

- be satisfied that the third party service provider has the necessary skills, expertise and training to collect the information required for the health assessment;
- have established how the information is to be collected and recorded (including any forms used);
- set or approve the quality assurance procedures for the information collection;
- be consulted on any issues arising during the information collection; and

review and analyse the information collected to prepare their report of the health assessment and communicate to the patient their recommendations about matters covered by the health assessment.

A.21.5 For items 704 and 706, a person is of Aboriginal or Torres Strait Islander descent if the person identifies himself or herself as being of that descent. Patients should be asked to self-identify their Indigenous status and state their age for the purposes of these items, either verbally or by completing a form. Difficulties may arise in relation to establishing the age of the patient. Knowledge of a person's age or date of birth is sometimes considered irrelevant by Indigenous people and as such some people may not be able to answer with a high degree of accuracy. The person's Indigenous status and age should be accepted on the basis of their self-identification.

A.21.6 A health assessment means the assessment of a patient's health and physical, psychological and social function and whether preventative health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

A.21.7 The assessment must include:

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

A.21.8 The assessment must also include keeping a record of the health assessment and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment. Where the patient has an informal or family carer, a copy of the report (or relevant extracts) should be offered to the carer, with the patient's agreement.

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

A.21.9 In circumstances where the patient's usual medical practitioner or practice, as defined in A21.2, does not undertake the health assessment, a copy of the health assessment report should be forwarded to that medical practitioner or practice (subject to the patient's agreement).
A.21.10 The annual health assessment should not take the form of a health screening service, in particular the assessment should not include Category 5 (diagnostic imaging) services or Category 6 (pathology) services unless the health assessment detects problems that require clinically relevant diagnostic imaging or pathology services. (See General Notes 13.3.)
A.21.11 Practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately.
A.21.12 Practitioners should establish a register of their patients seeking annual health assessments and remind registered patients when their next health assessment is due.
A.21.13 Where a component of the health assessment is conducted at consulting rooms and a component is conducted in the patient's home (including by a third party acting under the supervision of the practitioner) the latter item should be claimed.
A.21.14 The balance between the patient's health and physical, psychological and social function domains is a matter for professional judgement in relation to each patient. Practitioners should consider the following:

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

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

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

Immunisation status (Influenza, Tetanus, Pneumococcus)
Refer to the current Australian Standard Vaccination Schedule (NHMRC) for appropriate vaccination schedules for individuals in this age group.

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

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

Falls in last 3 months
The patient should be asked whether they have suffered any falls in the previous three months. A recent fall is the strongest predictor of future fall related injury.

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

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

Social function:
Availability and adequacy of paid and unpaid help when needed and wanted
This is the central component of an assessment of the patient's social support. People's social networks tend to become smaller as they age, and the role of formal services may need to increase correspondingly.

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

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

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

A.21.15 In addition, the assessment will usually cover additional matters of particular relevance to the patient. The medical literature and consensus medical opinion support the following additional components: multi-system review; fitness to drive; hearing; vision; oral health; diet and nutritional status; smoking; foot care; sleep; need for community services; home safety; cardiovascular risk factors, including blood pressure; and alcohol use.

A.21.16 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 between 15 years and 54 years of age (inclusive). 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.21.17 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.21.18 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.21.19 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.21.20 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.21.21 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 medical practitioner.

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

A.21.22 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.21.23 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.21. 24 **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.21.25 **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.21.26 **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.21.27 **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.21.28 **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.21.29 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.21.30 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.

A.21.31 COMPREHENSIVE MEDICAL ASSESSMENTS FOR RESIDENTS OF AGED CARE FACILITIES (Item 712)

The Comprehensive Medical Assessment complements other Medicare Benefits Schedule (MBS) items for services that medical practitioners (including general practitioners but not including specialists or consultant physicians) can provide to residents, including:

(a) normal consultations; and
(b) EPC items for contribution to a care plan and for case conferencing.

Patient Eligibility

A.21.32 This item applies to residents of a Residential Aged Care Facility. It does not apply to in-patients of a hospital or day hospital facility. A **Residential Aged Care Facility** (RACF) is a facility in which residential care services are provided, as defined in the Aged Care Act 1997. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a RACF if the person has been admitted as a permanent resident of that facility.

A.21.33 A CMA is a voluntary service. The resident's consent to a CMA should be obtained as per normal practice for obtaining consent to medical services.

Involving the resident's carer

A.21.34 Where the resident has an informal or family carer (see note A.21.8 above), the medical practitioner may find it useful to consider having the carer present for the CMA or components of the CMA (subject to the resident's agreement). The resident's carer may be able to provide useful information on matters such as medication usage and compliance, continence and physical, psychological and social function.

Where the provision of a CMA service involves consultation with a resident it should be read as including consultation with the resident's carer and/or representative where this is appropriate.

Medical Powers of Attorney and Advance Care Directives/Plans

A.21.35 It may be useful for a medical practitioner providing a CMA to know whether the resident has given anyone an enduring power of attorney (covering medical treatment) or equivalent, or whether a guardian with power to make decisions about the resident's medical treatment has been appointed. Where this is known it may be useful to document this in the patient's records.

It may also be useful to know whether an Advance Care Directive or Advance Care Plan (terms may differ by location) for care at end of life or other major life change has been prepared for the resident. Where such a document has been prepared it may be useful to consider what implications this may have for the provision of medical care for the resident. The resident's medical practitioner may also take the opportunity to discuss issues about the degree of medical intervention in the event of further deterioration in health status with the resident (if able) or guardian.

A.21.36 A CMA is available to **new residents** on admission into a RACF. Generally, it is recommended that new residents should receive a CMA as soon as possible after admission, preferably within six weeks following admission into a RACF.

A.21.37 A CMA is available for **existing residents** where it is required in the opinion of the resident's medical practitioner, for instance, because of a significant change in medical condition, physical and/or psychological function, associated with, for example (but not limited to):

(a) discharge from an acute care facility in the previous 4 weeks;
(b) significant changes to medication regimen in the last 3 months;
(c) change in medical condition or abilities;
(d) falls in the last three months;
(e) change in cognitive abilities and function;
(f) change in physical function including Activities of Daily Living.

A.21.38 The potential need for an "as required" CMA may be identified by the resident's medical practitioner, staff of the Residential Aged Care Facility, the resident and/or the resident's carer; or by any other member of the resident's health care team including a pharmacist providing medication management review services. The resident's medical practitioner must assess that the resident requires a CMA.

Usual GP

A.21.39 A CMA should generally be undertaken by the resident's 'usual GP'. This is broadly defined as the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months. Medical practitioners who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACF's as part of aged care panel arrangements, may also undertake CMAs for residents as part of their services.

A.21.40 **A maximum of one Medicare rebate is payable for a CMA for a resident in any twelve month period.**

Content of a Comprehensive Medical Assessment

A.21.41 A comprehensive medical assessment means a full systems review of the resident, including assessment of the resident's health and physical and psychological function. In undertaking a CMA, the medical practitioner may wish to consult appropriate guidelines (for example, the current edition of the Royal Australian College of General Practitioners (RACGP) publication: *Medical Care of Older Persons in Residential Aged Care Facilities* – the 'Silver Book'). Where practical, the medical practitioner may also use available knowledge and information from the RACF as relevant to the CMA.

A.21.42 A CMA of an aged care resident must include:

(a) taking a detailed relevant medical history;
(b) conducting a comprehensive medical examination of the resident;
(c) developing a list of diagnoses or problems based on the medical history and medical examination; and
(d) providing a written summary of the outcomes of the CMA for the resident's records to inform the provision of care for the resident by the RACF and to assist the reviewing pharmacist in providing medication management review services for the resident.

Elements of these components that would normally be undertaken, subject to the specific needs and circumstances of the resident, are set out below.

A.21.43 **A detailed relevant medical history** is an assessment of the resident's previous medical history and may include a review of:

- results of relevant assessments by previous GPs and/or specialists, including any relevant previous community-based assessments (such as EPC health assessments);
- results of relevant previous investigations and allied health interventions;
- results of assessment and intervention by nursing staff of the RACF;
- details of allergies and any drug intolerance;
- the resident's medication (including prescription and non-prescription drugs), to inform medication management review services for the resident;
- acute and chronic pain;
- falls in the last three months;
- immunisation status for influenza, tetanus and pneumococcus;
- continence; and
- factors leading to the admission into the RACF, taking into account the results of the resident's ACAT assessment.

A.21.44 **A comprehensive medical examination** is a full systems review of the resident. In undertaking the comprehensive medical examination the medical practitioner may wish to consider the following as appropriate to the resident**:**

(a) cardiovascular and respiratory systems, and other systems as indicated
(b) physical causes of acute and chronic pain;
(c) assessment of the resident's:
- physical function, including activities of daily living;
- psychological function, including cognition and mood;
- oral health, nutrition status and dietary needs; and
- skin integrity.

Developing a list of diagnoses and/problems

A.21.45 This should be based on the information from the medical history and examination of the patient. The list of diagnoses and/or problems is a useful output of the CMA and should form the basis of any actions to be taken as a result of the CMA. The list should be included in the summary of the CMA to facilitate the integration of the resident's medical care, medication review, care planning and provision of care by the aged care home.

A.21.46 **A written summary of the outcomes of the CMA** should contain sufficient information to serve as a communication tool from the medical practitioner to other health and care providers involved in the care of the resident. The medical practitioner may wish to include a list of diagnoses and problems and recommendations concerning the care of the resident.

A copy of this summary should be provided to the RACF to inform the provision of care by the RACF for the resident and to assist the reviewing pharmacist in providing medication management review services for the resident.

The medical practitioner may wish to offer the resident (and their carer where appropriate) a copy of the summary or relevant parts thereof.

Where a facility uses a care documentation system that the medical practitioner considers relevant to the CMA, the medical practitioner may consider documenting the CMA outcomes of the CMA in that system or in a way that can be integrated with the facility's system.

A.21.47 **Additional matters of particular relevance to the resident -** the CMA will usually cover additional matters of particular relevance to the resident. The following additional components may be undertaken where and as relevant to the resident: fitness to drive; hearing; vision; smoking; foot care; sleep; cardiovascular risk factors; and alcohol use.

A.21.48 On completion of the CMA, the medical practitioner may consider referral to appropriate allied health providers, noting that this may involve a cost to the resident. Any follow up work following completion of the CMA should be treated as a different service.

A.21.49 The CMA should not take the form of a health screening service, in particular the CMA should not include category 5 (diagnostic imaging) services or category 6 (pathology) services unless the CMA detects problems that require clinically relevant diagnostic imaging or pathology services.

Combining with other consultation items

A.21.50 The CMA item covers the consultation at which the CMA service is undertaken:
(a) if a consultation is for the purpose of undertaking a CMA only, only the CMA item can be claimed;
(b) if a CMA is undertaken during the course of a consultation for another purpose, the CMA item and the relevant item for the other consultation may both be claimed;
(c) any immediate action required to be done at the time of completing a CMA, based on and as a direct result of information gathered in the CMA, should be treated as part of the CMA;
(d) any follow up after the completion of the CMA should be treated as a separate consultation item; and
(e) CMA's do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

A.22 Chronic Disease Management Items (Items 721 to 731)

A.22.1 This note refers to new Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items. These new items replace the former items for multidisciplinary care planning services – items 720, 722, 724, 726, 728 and 730.

A.22.2 New EPC Medicare items 721, 723, 725, 727, 729 and 731 provide rebates for GPs to manage chronic disease by preparing, coordinating, reviewing or contributing to CDM plans. These new items were developed in consultation with GP groups to improve the operation of the EPC items and reduce red tape.

A.22.3 Where patients have existing EPC multidisciplinary care plans, it is not necessary to prepare a new plan using the new items until required by the patient's circumstances. EPC multidisciplinary care plans can be reviewed using the new CDM review items. (See A.22.51 for more information on transitional arrangements).

A.22.4 The care and treatment provided to the patient when implementing a GPMP or TCA (including when reviewed) should be provided through normal consultation items. The EPC chronic disease management items are not substitutes for normal medical care and treatment.

A.22.5 The new CDM items are able to be claimed by a medical practitioner, including a general practitioner but not including a specialist or consultant physician. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim these items.

Overview
A.22.6 The new EPC chronic disease management items are for:

- preparation by a GP of a GP Management Plan (GPMP);
- coordination by a GP of Team Care Arrangements (TCA);
- review by a GP of a GP Management Plan;
- coordination by a GP of a review of Team Care Arrangements;
- contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for patients who are not residents of aged care facilities); and
- contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for residents of aged care facilities).

GPMPs and TCAs should be comprehensive documents that set out and enable evidence-based management of the patient's health and care needs. The recommended frequency for these services, allowing for variation in patients' needs, is once every two years, with regular reviews (recommended six monthly) of the patient's progress against the plan. This is recommended as an average frequency but should be applied with regard to the patient's requirements – in general, a new GPMP and/or TCA should not be prepared unless and until required by the patient's condition, needs and circumstances. The review items are the key components for assessing and managing the patient's progress once a GPMP or TCA have been prepared.

A.22.7 Patients with a chronic or terminal medical condition are eligible for a GP Management Plan item. Patients who also have complex needs requiring care from a multidisciplinary team are also eligible for a Team Care Arrangements item.

A.22.8 A GP Management Plan and Team Care Arrangements, together, broadly equate to an EPC multidisciplinary plan.

A.22.9 While a GP Management Plan and a Team Care Arrangements are able to be provided independently, it is expected that in most cases a patient with complex needs would have both services. It is not mandatory, however, to follow the preparation of a GP Management Plan with the coordination of Team Care Arrangements or to prepare a GP Management Plan before coordinating Team Care Arrangements.

A.22.10 For patients to be eligible to access rebates under the allied health and dental care items (item numbers 10950 to 10977 inclusive) they must have both a GP Management Plan and a Team Care Arrangements in place and claimed on Medicare. However, residents of aged care facilities are eligible to access rebates under the allied health and dental care items where their GP has contributed to a care plan prepared for them (Item 731) and the contribution item has been claimed on Medicare (see A.22.38 and A.22.39).

PREPARING A GP MANAGEMENT PLAN (GPMP) – (Item 721)
A.22.11 This item is for patients with a chronic or terminal medical condition who will benefit from a structured approach to management of their care needs. A rebate can be claimed once the patient's usual GP (or another GP in the same practice) has prepared a GPMP by completing the steps at A.22.12 and meeting the relevant requirements listed under A.22.40 and A.22.41 The GP may be assisted by their practice nurse, Aboriginal Health Worker or other health professional in the GP's medical practice or health service (see A.22.43). The service must include a personal attendance by the GP with the patient, as part of Item 721.

A.22.12 The steps in preparing a GPMP must include:

a) assessing the patient to identify and/or confirm all of the patient's health care needs, problems and relevant conditions;
b) agreeing management goals with the patient for the changes to be achieved by the treatment and services identified in the plan;
c) identifying any actions to be taken by the patient;

d) identifying treatment and services that the patient is likely to need, and making arrangements for provision of these services and ongoing management; and
e) documenting the patient needs, goals, patient actions, treatment/services and a review date i.e. completing the GPMP document;

The GP may, with the permission of the patient, provide a copy of the GPMP or of relevant parts of the GPMP, to other providers involved in the patient's care.

A.22.13 This GP service is available to patients in the community. It is also available to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital, where their usual GP (or a GP from the same practice) who prepares the GPMP is providing in-patient care; in this case the GPMP is claimed as an in-hospital service. A GPMP is not available to public in-patients being discharged from hospital. It is not available to residents of aged care facilities, except where they are private-in patients being discharged from hospital.

A22.14 Depending on variations in patients' needs, a new GPMP may be required around once every two years, with regular reviews (recommended six monthly) of the patient's progress against the plan. In general, a new GPMP should not be prepared unless required by the patient's condition, needs and circumstances, however, the minimum claiming interval for this item is twelve monthly, to allow for completion of a new GPMP where required. This means that a rebate will not be paid within twelve months of a previous claim for a GPMP, within twelve months of a claim for former item 720 (preparation of a community care plan) or within three months of any other EPC chronic disease management item, other than in exceptional circumstances eg repeated discharge from hospital (see A.22.49 and A.22.50).

COORDINATING THE DEVELOPMENT OF TEAM CARE ARRANGEMENTS (TCA) – (Item 723)

A22.15 This item is for patients with a chronic or terminal medical condition and who require ongoing care from a multidisciplinary team of their GP and at least two other health or care providers. A rebate can be claimed once the patient's usual GP (or a GP in the same practice) has coordinated the development of TCA by completing the steps at A.22.17 and meeting the relevant requirements listed under A.22.40 and A.22.41. The GP may be assisted by their practice nurse, Aboriginal Health Worker or other health professional in the GP's medical practice or health service (see A.22.43). The service must include a personal attendance by the GP with the patient as part of item 723.

A.22.16 This service can be provided to patients who have a current GPMP or to those patients whose care is, in the opinion of the providing GP, appropriately managed at the GP level without a GPMP.

A.22.17 The steps in coordinating TCA must include:

a) discussing with the patient which treatment/service providers should be asked to collaborate with the GP in completing TCA;
b) gaining the patient's agreement to share relevant information about their medical history, diagnoses, GPMP etc (with or without restrictions) with the proposed providers;
c) contacting the proposed providers and obtaining their agreement to participate, realising that they may wish to see the patient before they provide input but that they may decide to proceed after considering relevant documentation, including any current GPMP;
d) collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient;
e) documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, any actions to be taken by the patient and a review date i.e. completing the TCA document; and
f) providing the relevant parts of the TCA to the collaborating providers and to any other persons who, under the TCA, will give the patient the treatment/services mentioned in the TCA.

The GP may, with the permission of the patient, provide a copy of the TCA or of relevant parts of the TCA, to other providers involved in the patient's care.

A.22.18 The collaboration between the coordinating GP and participating providers at A.22.17 (d) must be based on two-way communication between them, preferably oral, or, if this is not practicable, in writing (including by exchange of fax or email, but noting that the means of communication used must enable privacy to be safeguarded in relation to patient information). It should relate to the specific needs and circumstances of the patient. The communication from providers must include advice on treatment and management of the patient.

A.22.19 To develop Team Care Arrangements for a patient, at least two health or care providers who will be providing ongoing treatment or services to the patient must collaborate with the GP in the development of the TCA. This includes people who will be organising or coordinating care services for the patient that will be provided by their organisation. Each of the health or care providers must provide a different kind of ongoing care to the patient. One of the minimum two service

providers collaborating with the GP may be another medical practitioner (normally a specialist or consultant physician but not usually another GP). The patient's informal or family carer may be included in the collaborative process but does not count towards the minimum of three collaborating providers (see A.22.47).

A.22.20 Once a GPMP (item 721) and TCA (item 723) have been prepared for a patient and claimed on Medicare (or item 731 for aged care residents), the patient is eligible for access to certain allied health and dental services (items 10950 to 10977 inclusive). The patient can be referred by their GP for services identified in their TCA after the TCA has been completed and claimed. Medicare rebates are not payable for allied health providers' involvement in contributing to the development of the TCA or the review of the TCA.

A.22.21 A TCA should document all the health or care services required to address the patient's needs – this should include services to be provided by people or organisations that are not members of the TCA team.

A.22.22 This GP service is available to patients in the community. It is also available to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital, where their usual GP (or a GP from the same practice) is coordinating the development of the TCA and is providing in-patient care; in this case the TCA is claimed as an in-hospital service. A TCA is not available to public in-patients being discharged from hospital. It is not available to residents of aged care facilities, except where they are private in-patients being discharged from hospital.

A.22.23 Depending on variations in patients' needs, a new TCA may be required around once every two years, with regular reviews (recommended six monthly) of the patient's progress against the plan. In general, a new TCA should not be prepared unless required by the patient's condition, needs and circumstances, however, the minimum claiming interval for this item is twelve monthly, to allow for completion of a new TCA where required. This means that a rebate will not be paid within twelve months of a previous claim for a TCA, within twelve months of a claim for former item 720 (preparation of a community care plan) or within three months of any other EPC chronic disease management item, other than in exceptional circumstances eg repeated discharge from hospital (see A.22.49 and A.22.50).

REVIEWING A GP MANAGEMENT PLAN – (Item 725)

A.22.24 This item is for patients who have a current GPMP in place and who will benefit from a review of that GPMP. A review is the principal mechanism for ensuring the continued appropriateness of the GPMP and the management of the patient's chronic condition. A rebate can be claimed once the GP who prepared the patient's last GPMP (or another GP in the same practice or a new GP where the patient has changed practices) has undertaken a systematic review of the patient's progress against the GPMP goals by completing the steps at A.22.25 and meeting the relevant requirements listed under A.22.40 and A.22.41. The GP may be assisted by their practice nurse, Aboriginal Health Worker or other health professional in the GP's medical practice or health service (see A.22.43). The service must include a personal attendance by the GP with the patient, as part of item 725.

A.22.25 The steps in reviewing a GPMP must include:

a) reviewing the patient's needs and goals, patient actions and treatment/services;
b) making relevant changes to the documented GPMP; and
c) adding a new review date;

The GP may, with the permission of the patient, provide a copy of the reviewed GPMP or of relevant parts of the reviewed GPMP, to other providers involved in the care of the patient.

A.22.26 This GP service is available to patients in the community. It can also be used to review GPMPs prepared for private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital; in most cases such post-discharge reviews would be undertaken when the patient is living in the community setting.

A.22.27 The recommended frequency of this service is once every six months. A rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for preparing a GPMP, other than in exceptional circumstances.

COORDINATING A REVIEW OF TEAM CARE ARRANGEMENTS – (Item 727)

A.22.28 This item is for patients who have a TCA in place and who will benefit from a team-based review of the TCA. A rebate can be claimed once the GP who coordinated the development of the patient's TCA (or another GP in the same practice or a new GP where the patient has changed practices) has coordinated a systematic team-based review of the patient's progress against the TCA goals by completing the steps at A.22.29 and meeting the relevant requirements listed under A.22.40 and A.22.41. The GP may be assisted by their practice nurse, Aboriginal Health Worker or other health professional in the GP's medical practice or health service (see A.22.43). The service must include a personal attendance by the GP with the patient as part of item 727.

A.22.29 The steps in coordinating a review of TCA must include:

a) discussing or confirming with the patient which treatment/service providers should be asked to collaborate with the GP in the review and gaining agreement to share relevant information with them;
b) collaborating with the participating providers to establish the patient's progress against the previously nominated treatment/service goals, and agreeing on any necessary changes and on the specific treatment/services to be provided by each member of the team;
c) making necessary changes to the documented TCA; and
d) providing the relevant parts of the revised TCA (if any) to the collaborating providers and to any other persons who, under the revised TCA, will give the patient treatment/services mentioned in the TCA.

A.22.30 See A.22.18 and A.22.19 for information on collaboration and on the required number and roles of collaborating providers.

A.22.31 This GP service is available to patients in the community. It can also be used to review TCAs prepared for private in-patients (including those private in-patients who are residents of aged care facilities) being discharged from hospital; in most cases such post-discharge reviews would be undertaken when the patient is living in the community setting.

A.22.32 The recommended frequency of this service is once every six months. A rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for coordinating the development of TCA, other than in exceptional circumstances such as hospital discharge (see A.22.49 and A.22.50).

CONTRIBUTING TO A MULTIDISCIPLINARY CARE PLAN OR CONTRIBUTING TO A REVIEW OF A MULTIDISCIPLINARY CARE PLAN FOR A PATIENT WHO IS NOT A RESIDENT OF AN AGED CARE FACILITY – (Item 729)

A.22.33 This item is for patients who are having a multidisciplinary care plan (which may include Team Care Arrangements) prepared or reviewed for them by another health or care provider (i.e. other than their usual GP). Other health or care providers include (but are not limited to) allied health providers, home or community service providers and medical specialists, but not usually other GPs. A rebate can be claimed once the patient's usual GP (or another GP in the same practice) has contributed to the care plan or to the review of the care plan being prepared by the other provider, by completing the steps at A.22.34.

A.22.34 The steps involved in contributing to a multidisciplinary care plan or to a review of the care plan must include:

a) gaining or confirming the patient's agreement for the GP to contribute to the care plan or to the review of the care plan and to share relevant information with the other providers;
b) collaborating with the person preparing the care plan to set goals and specify treatment/services to be provided by the GP;
c) adding to the patient's records a copy or notation of the GP's contribution to the plan (either the treatment/services to be provided by the GP or the GP's advice to the person preparing the plan).

A.22.35 See A22.18 and A.22.19 on collaboration and communication.

A.22.36 This GP service is available to patients in the community and to both private and public in-patients being discharged from hospital. It is not available to patients who are residents of aged care facilities (see item 731 below).

A.22.37 The recommended frequency of this service is once every six months. Other than in exceptional circumstances, a rebate will not be paid within twelve months of a GPMP or TCA claimed by the same practitioner for that patient, within three months of a previous claim for the same item or within three months of a claim for other EPC review or contribution items.

CONTRIBUTING TO ANOTHER PROVIDER'S MULTIDISCIPLINARY CARE PLAN OR CONTRIBUTING TO A REVIEW OF A MULTIDISCIPLINARY CARE PLAN FOR A PATIENT WHO IS A RESIDENT OF AN AGED CARE FACILITY –(Item 731).

A.22.38 This item, including the components of the service, is similar to Item 729 (see A.22.33 to A.22.37 inclusive) except that:

(a) this service is only available to residents of aged care facilities;
(b) this service can only be provided to a resident where the multidisciplinary plan is being prepared by the aged care facility or by a hospital from which the resident is being discharged;
(c) a contribution to a care plan for an aged care resident must be at the request of the aged care facility or the discharging hospital;

(d) the GP's contribution should be documented in the care plan maintained by the aged care facility or discharging hospital and a record included in the resident's medical record; and
(e) a rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for other EPC CDM items.

A.22.39 Where a resident's GP has contributed to a care plan prepared by the aged care facility or discharging hospital for the resident, the resident is eligible to access rebates under the allied health and dental care items (item numbers 10950 to 10977 inclusive).

ADDITIONAL INFORMATION

A.22.40 Before proceeding with any EPC CDM service (other than a care plan contribution under items 729 and 731) the GP must ensure that:

(a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer;
(b) in the case of TCA and TCA review services, any likely out-of-pocket costs to the patient for the involvement of other providers are explained to the patient; and
(c) the patient's agreement to proceed is recorded.

Note that Medicare rebates are only payable for certain allied health and dental services, provided to the patient on referral from the patient's GP, after both a GPMP and TCA are in place and claimed on Medicare or after item 731 (for aged care residents) is in place and claimed on Medicare. Medicare rebates are not payable for allied health providers' involvement in contributing to the development of TCAs, multidisciplinary care plans, TCA reviews or multidisciplinary care plan reviews.

A.22.41 Before completing any EPC CDM service (other than a contribution item) and claiming a benefit for that service, the GP must offer the patient a copy of the relevant document and add the document to the patient's record.

A.22.42 For the purpose of paragraphs A.22.1 to A.22.52:

(a) "a chronic medical condition" is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions;

(b) "the patient's usual GP" means the GP, or a GP working in the medical practice, that has provided the majority of care to the patient over the previous 12 months and/or will be providing the majority of care to the patient over the next 12 months; and

(c) offering a copy of a documented GPMP, documented TCA or a reviewed or amended version of either of them to a patient should include, if the patient permits, offering a copy to their carer, where appropriate.

A.22.43 A practice nurse, Aboriginal Health Worker or other health professional may assist a GP in preparing or reviewing a GPMP or TCA (for example in patient assessment, identification of patient needs and making arrangements for services), however, the GP must review and confirm all assessments and elements of the GPMP, TCA, reviewed GPMP or reviewed TCA and must see the patient.

A.22.44 The GP Management Plan and Team Care Arrangements CDM items cover the consultations at which the relevant items are undertaken, noting that:

(a) If a consultation is for the purpose of undertaking the GPMP or TCA item only, only the relevant GPMP or TCA item can be claimed.

(b) If a GPMP or TCA item is undertaken or initiated during the course of a consultation for another purpose, the GPMP or TCA item and the relevant item for the other consultation may both be claimed.

In general, a separate consultation should not be undertaken in conjunction with a GPMP or TCA item unless it is clinically indicated that a problem must be treated immediately. In this case the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (eg separate consultation clinically required/indicated).

A.22.45 A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

A.22.46 Whenever an EPC chronic disease management service is available to a hospital private in-patient and is provided to that patient in a hospital, the Medicare voucher (assignment of benefit) or patient invoice must be marked accordingly. In-hospital services attract a Medicare rebate at 75% of the schedule fee. See 7.1.2(vi) of the General Explanatory Notes.

A.22.47 If a patient agrees, their informal or family carer may be involved in the preparation/review of the GPMP and/or the development/review of TCA, having regard to the patient's circumstances, the degree of support provided by the carer for the patient and the capacity of the carer to provide ongoing support to the patient and to participate in the relevant processes. The patient and their informal or family carer do not count as one of the minimum three members of the multidisciplinary team.

A.22.48 Where a patient changes practices, so that a GP in the new practice becomes the patient's usual GP, the new GP may use item 725 or item 727 as appropriate to review the patient's existing GPMP or TCA, in accordance with the requirements of those items, at the request of the patient or their carer.

Exceptional circumstances

A.22.49 There are minimum time intervals for payment of rebates for EPC chronic disease management items (as detailed above), with provision for claims to be made earlier than these minimum intervals in exceptional circumstances. 'Exceptional circumstances' apply where there has been a significant change in the patient's clinical condition or care circumstances that require a new GPMP or TCA or a new review, rather than, for example, amending the existing GPMP or TCA.

A.22.50 Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher (assignment of benefit form) should be annotated to briefly indicate the reason why the service involved was required earlier than the minimum time interval for the relevant item (eg annotated as clinically indicated, discharge, exceptional circumstances, significant change etc).

Transitional Arrangements and Reviewing EPC Multidisciplinary Care Plans from 1 July 2005

A.22.51 Where a patient was being managed under an active EPC multidisciplinary care plan (former Item 720 or former Item 722) before 1 July 2005, that patient will be regarded as having both a GP Management Plan and Team Care Arrangements in place from the date on which the active multidisciplinary care plan was completed and claimed. In order to review an existing EPC multidisciplinary care plan from 1 July 2005, a GP can use the relevant CDM review items (a GPMP Review item for review by a GP of a GPMP, or a TCA Review item for team-based review of a TCA).

A.23 Case Conferences by medical practitioners (other than specialist or consultant physician) (Items 734 to 779)

A.23.1 Items 740, 742, 744, 759, 762 and 765 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is not an in-patient of a hospital, day hospital facility or a care recipient in a residential aged care facility.

A.23.2 Items 746, 749, 757, 768, 771 and 773 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is an in-patient of a hospital or day hospital facility and is not a care recipient in a residential aged care facility.

A.23.3 Items 734, 736, 738, 775, 778 and 779 apply only to a service in relation to a care recipient in a residential aged care facility who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

A.23.4 A case conference is a process by which a case conference team carries out the following activities:

(a) discussing a patient's history; and

(b) identifying the patient's multidisciplinary care needs; and

(c) identifying outcomes to be achieved by members of the case conference team giving care and service to the patient; and

(d) identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and

(e) assessing whether previously identified outcomes (if any) have been achieved.

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

A.23.5 For items 746, 749, 757, 768, 771 and 773, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility.

A.23.6 For the purposes of items 734 to 779 a medical practitioner should generally be the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.23.7 A case conference team includes a medical practitioner and at least two other members, who participate in the case conference, each of whom provides a different kind of care or service to the patient, and one of whom may be another medical practitioner (normally a specialist or consultant physician).

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

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

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

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.
The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Organisation of a case conference
A.23.8 Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:
(a) explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and
(b) recording the patient's agreement to the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in A.23.4 and putting a copy of that record in the patient's medical records; and
(f) offering the patient (and the patient's carer, if appropriate and with the patient's agreement), and giving each other member of the team a summary of the conference; and
(g) discussing the outcomes of the case conference with the patient.

A.23.9 Organisation of a discharge case conference (items 746, 749 and 757), may be provided for private in-patients only, and must be organised by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner).

Participation in a case conference
A.23.10 Participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes ensuring that the following activities are completed and documented in the patient's medical records:
(a) explaining to the patient the nature of a case conference, and asking the patient whether he or she agrees to the medical practitioner participating in the case conference; and
(b) recording the patient's agreement to the medical practitioner participating in the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in A.23.4 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records; and
(f) offering the patient (and the patient's carer, if appropriate and with the patient's agreement) a summary of the conference.

Case conferences in a residential aged care facility
A.23.11 For items 734, 736, 738, 775, 778 and 779, organising or participating in a case conference in a residential aged care facility means undertaking the relevant activities referred to in A.23.4, A.23.8 and A.23.10. For these items the medical practitioner must give a record of the conference, or a record of the medical practitioner's participation in the conference, to the residential aged care facility, place a copy in the patient's medical records, and offer a copy to the patient and to the patient's carer, if appropriate and with the patient's agreement.

General requirements
A.23.12 In circumstances where the patient's usual medical practitioner, as defined in A22.4, is not a member of the case conference team, a record of the case conference should be forwarded to that medical practitioner (subject to the patient's agreement).
A.23.13 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.
A.23.14 The case conference must be arranged in advance within a time frame that allows for all the participants to attend. The minimum three care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.
A.23.15 In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:

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

A.23.16 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. (See General Notes 7.6)

Allied health and dental care services

A.23.17 Medicare benefits for some allied health and dental care services are available to people with chronic conditions and complex care needs that are being managed through an Enhanced Primary Care (EPC) plan. Patients must be referred for these services by a medical practitioner (including a general practitioner but not including a specialist or consultant physician).

A.23.18 Medicare rebates are available for a total of five allied health services and three dental care services per year for each eligible patient. Currently the 'year' commences on the dates the patient receives their first allied health and dental care services respectively. From 1 January 2006 the 'year' will mean 'calender year'. The allied health items (10950-10970 inclusive) may be found at Group M3 of the MBS book. The dental care items (10975-10977 inclusive) may be found at Group M4 of the MBS book.

Referral requirements

A.23.19 To be eligible for rebates for allied health and dental care services, patients must have an EPC plan (MBS items 720,722, 730 or 731; or 721 and 723) and the allied health/dental care services must be recommended in that plan.

A.23.20 The patient must be referred by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) using an '*EPC program referral form for allied health services under Medicare*' or an *EPC program referral form for dental care services under Medicare* (the referral form) whichever is relevant. The referring medical practitioner should complete and sign the referral form.

A.23.21 Medical practitioners may use one form to refer patients for single or multiple services of the same service type. If referring a patient for a single or multiple services of *different* service types (for example, one dietetic service and three podiatry services) a separate referral form will be needed for each service type.

Referral forms may be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing the Department on (02) 6289 7120. Copies of completed referral forms signed by the servicing allied health professional or dentist are no longer required to accompany Medicare claims. Therefore, medical practitioners may modify the relevant *EPC program referral form for allied health (or dental care) services under Medicare* to suit the needs of their practice.

Eligible allied health services

A.23.22 Eligible allied health services are those provided by:

- Aboriginal health workers; audiologists; chiropodists; chiropractors; diabetes educators; dietitians; mental health workers; occupational therapists; osteopaths; physiotherapists; podiatrists; psychologists; and speech pathologists.

A.23.23 Eligible patients may receive a Medicare rebate for a maximum of five allied health services a year (that is five services in total each year, across all types of eligible services).

Eligible dental services

A.23.24 Where patients whose needs are being managed under an EPC plan also have dental problems that are significantly exacerbating their chronic condition, a Medicare rebate for a maximum of three dental services (in total) a year is available.

A.23.25 Common examples of circumstances where a dental condition can exacerbate a chronic and complex disease might include (but are not restricted to):

(a) where the patient has valvular heart disease and poor oral hygiene and gum disease (putting them at the risk of developing bacterial endocarditis);
(b) where the patient has diabetes and poor oral hygiene (such as tooth abscesses, and where infection can compromise the management of their diabetes);
(c) where the patient has malignancies of the head and neck where surgery (or radiation) has resulted in damage to the oral cavity, or has exacerbated underlying dental disease (and affects eating); or
(d) where the patient has baseline poor oral health and experience significant worsening while undergoing chemotherapy or is immuno-suppressed.

A.23.26 There are three (3) dental care items: 10975 (dental assessment); 10976 (dental treatment); and 10977 (dental assessment or treatment by a registered dentist or dental specialist on referral from another dentist). All patients are required to have a dental assessment (item 10975) prior to dental treatment (item 10976) or further assessment and treatment by a dental specialist (item 10977). Dentists may provide dental treatment on the same day as a dental assessment if clinically indicated. These services will count as two of the three annual services available.

Feedback to the referring medical practitioner

A.23.27 On completion of each service, the allied health professional must provide a written report to the referring medical practitioner. The written report provided by the allied health professional after each service, should include, for example, notification of:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

The only exception to this is when an allied health professional provides more than two Medicare rebateable services to the same patient under the same referral. In this case, the allied health professional must provide a written report to the referring medical practitioner after the first and last Medicare rebateable services only, or more often if clinically necessary.

A.23.28 The written report provided by the dentist after the dental assessment (item 10975) should include:

- the findings of the evaluation and prognosis;
- the proposed treatment, including the likely number of visits, and an estimated cost of each visit, or the total treatment; and
- any specific investigations that would be required (such as radiology or pathology services) that would assist in the management of the dental condition as it relates to the chronic and complex medical condition.

A.23.29 If a dental assessment is carried out by a dental specialist under item 10977, a similar report should be provided to the referring dentist and to the referring medical practitioner. A copy of all dental assessments should also be offered to the patient.

Allied health professional/ dentist eligibility

A.23.30 Allied health professionals, dentists and dental specialists providing services under the items must be registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, an allied health professional, dentist or dental specialist needs to be:

(a) a recognised professional who is registered under relevant State or Territory law; or
(b) where there is no such State or Territory law, a practitioner who is a member of a professional association with uniform national registration requirements.

Further details may obtained from Medicare Australia by calling 132 150. Information can also be found at www.medicareaustralia.gov.au

Medicare rebates

A.23.31 Services provided under the allied health and dental care items will not attract a Medicare rebate unless an EPC Item 720 or 722; or items 721 and 723; (or in the case of aged care facility residents, an EPC Item 730 or 731) has already been claimed. Patients are required to provide an itemised account/receipt from the allied health professional or dentist to Medicare Australia in order to claim a Medicare rebate. The account/receipt must include:

- the name and provider number of the allied health professional or dentist;
- the Medicare item number; and
- the referring medical practitioners name, provider number and date of referral.

Services not included

A.23.32 The allied health and dental care items do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital or day-hospital facility.

A22.33 Where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the allied health and dental care items apply for services that are provided by eligible allied health professionals and dentists salaried by, or contracted to, the service.

Private health insurance

A.23.34 Patients need to decide if they will use Medicare rebates or their private health insurance ancillary cover to pay for allied health and dental care services. Patients cannot use private health insurance ancillary cover to 'top up' the Medicare rebate paid for allied health or dental care services.

A.24 Public Health Medicine (Items 410 to 417)

A.24.1 Attendances by public health physicians will attract Medicare benefits under the new items only where the attendance relates to one or more of the following: -

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

A.25 Case Conferences by consultant physician (Items 820 to 838)

A.25.1 Items 820, 822, 823, 825, 826 and 828 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and has complex needs requiring care from a multidisciplinary team. Items 820, 822, 823, 825, 826 and 828 do not apply to an in-patient of a hospital or day hospital facility.

A.25.2 For items 830, 832, 834, 835, 837 and 838, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility. Items 830, 832, 834, 835, 837 and 838 are payable not more than once for each hospital admission.

A.25.3 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A.25.4 A case conference is a process by which a multidisciplinary team carries out the following activities:

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

A.25.5 For the purposes of items 820, 822, 823, 830, 832 and 834 (that is, where a consultant physician organises a case conference) a multidisciplinary team requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of four.

A25.6 For the purposes of items 825, 826, 828, 835, 837 and 838 (that is, where a consultant physician participates in a case conference) a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant physician is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of three.

A.25.7 For the purposes of A.25.5 and A25.6, "formal care providers" includes:

- the patient's usual General Practitioner;
- allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist; dietician; psychologist; orthoptist; orthotist and prosthetist, optometrist; audiologist, social worker, Aboriginal health worker, mental health worker, asthma educator, diabetes educator, dental therapist, dentist; and
- community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference

A.25.8 For items 820, 822, 823, 830, 832 and 834, organise and coordinate a community case conference means undertaking the following activities in relation to a case conference:

(a) explaining to the patient or the patient's agent the nature of a case conference, and asking the patient or the patient's agent whether he or she agrees to the case conference taking place; and
(b) recording the patient's or agent's agreement to the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in A.25.4 and putting a copy of that record in the patient's medical records; and
(f) giving the patient or the patient's agent, and each other member of the team a summary of the conference; and
(g) giving a copy of the summary of the conference to the patient's usual general practitioner; and
(h) discussing the outcomes of the patient or the patient's agent.

Participation in a case conference

A.25.9 For items 825, 826, 828, 835, 837 and 838, participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:

(a) recording the day on which the conference was held, and the times at which the conference started and ended; and
(b) recording the matters mentioned in A.25.4 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records.

General requirements

A.25.10 The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three care providers for participating in a case conference or four care providers for organising a case conference must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.25.11 A record of the case conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the problems, goals and strategies; and a summary of the outcomes must be kept in the patient's record. The notes and summary of outcomes must be provided to all participants and to the patient's usual general practitioner.

A.25.12 Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the consultant physician should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants;
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other care providers;
- Inform the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

A.25.13 Medicare benefits are only payable in respect of the service provided by the coordinating consultant physician or the participating consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for participation by other medical practitioners at a case conference, except where a medical practitioner organises or participates in a case conference in accordance with Items 734 to 779.

A.25.14 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. See point 7 of the General Explanatory Notes for further details on billing procedures.

A.25.15 It is expected that a patient would not normally require more than 5 case conferences in a 12 month period.

A.25.16 This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

A.26 Attendances by Medical Practitioners who are Sports Physicians

A.26.1 Items 444 to 447 relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australian College of Sport Physicians (FACSP) and who participate in, and meet the requirements for, quality assurance and continuing medical education as required by the ACSP.

A.26.2 Items 444 to 447 cover four categories of attendance based largely on the tasks undertaken by the practitioner during the attendance on the patient rather than simply on the time spent with the patient.

A.26.3 The attendances are divided into four categories relating to the level of complexity, namely:

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

A.26.4 To assist medical practitioners who are sports physicians in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

LEVEL 1

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

LEVEL 2

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

LEVEL 3

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

level, eg - if an attendance involved a detailed history and examination of multiple systems, arranging investigations and implementing a management plan, but the time taken was less than 20 minutes, it would constitute a Level 2 attendance.

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

Recording Clinical Notes
A. 26.5 In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance
A.26.6 Where, during the course of a single attendance by medical practitioners who are sports physicians, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see paragraph 14.3 of the General Explanatory Notes for further details).

A.27 Medication Management Reviews
Domiciliary Medication Management Review (Item 900)
A.27.1 This item is available to people living in the community setting who meet the criteria for DMMR. The item is not available for in-patients of a hospital, day hospital facility, or care recipients in residential aged care facilities. Patients may also refer to DMMR as *Home Medicines Review*.
A.27.2 This item should generally be undertaken by the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.
A.27.3 DMMR's are targeted at patients who are likely to benefit from such a review, and for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or because of a lack of knowledge and skills to use medicines to their best effect.
A.27.4 A medical practitioner must assess that a DMMR is clinically necessary to ensure quality use of medicines or address patient's needs. Examples of risk factors known to predispose people to medication related adverse events are:

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

A.27.5 For item 900 a DMMR includes all DMMR-related services provided by the medical practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

- The potential need for a DMMR may be identified either by the medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.
- The medical practitioner must assess the clinical need for a DMMR from a quality use of medicines perspective with the patient as the focus, and formally initiate a DMMR if appropriate.
- If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.
- If the consultation at which the medication management review is initiated is only for the purposes of initiating the review only item 900 should be claimed.
- If the medical practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.
- The item covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the patient. Any immediate action required to be done at the time of completing the DMMR (eg writing prescriptions or making referrals) should be

treated as part of the DMMR item. Any subsequent follow up should be treated as a normal consultation item.

- Practitioners should not conduct a separate consultation in conjunction with completing the DMMR unless it is clinically indicated that a problem must be treated immediately.
- The benefit is not claimable and an account should not be rendered until all components of this item have been rendered (See General Notes 7, Billing Procedures).
- Where a DMMR cannot be completed due to circumstances beyond the control of the medical practitioner (for example, because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

A.27.6 The process of ***referral to a community pharmacy*** includes:

- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless the patient prefers another location or other exceptional circumstances apply), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and
- Provision to the patient's preferred community pharmacy, of relevant clinical information, by the medical practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.
- A DMMR referral form is available for this purpose, if this form is not used the medical practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy.

A.27.7 The ***discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist*** includes:

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

A.27.8 Development of ***a written medication management plan following discussion with the patient*** includes:

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

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

A.27.9 Benefits for a DMMR service under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (for example, diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

Residential Medication Management Review (Item 903)

A.27.10 Residential Medication Management Reviews (RMMR) are collaborative services available to residents of a Residential Aged Care facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

A.27.11 RMMR complements other Medicare Benefits Schedule (MBS) items for services that a medical practitioner can provide to residents including:

- normal consultations;
- EPC items for contributing to a care plan and for case conferencing; and
- Comprehensive Medical Assessments.

A.27.12 RMMRs are available to:

- **new residents** on admission into a RACF; and
- **existing residents on an 'as required' basis,** where in the opinion of the resident's medical practitioner, it is required, because of a significant change in medical condition or medication regimen.

Medicare benefits are payable for a maximum of one RMMR for a resident in any 12 month period, except where there has been significant change in medical condition or medication regimen requiring a new RMMR.

A.27.13 RMMRs are not available to people receiving respite care in a Residential Aged Care Facility. Home Medicines Reviews are available to these people when they are living in the community setting.

A.27.14 Where the provision of RMMR services involves consultation with a resident it should be read as including consultation with the resident and/or their carer or representative where appropriate.

A.27.15 An RMMR service should be completed within a reasonable timeframe. As a guide it is expected that most

RMMR services would be completed within four weeks of being initiated.

Patient Eligibility

A.27.16 This item is available to residents of a Residential Aged Care Facility (RACF). It is not available to in-patients of a hospital, a day hospital facility, people receiving respite care in a RACF, or people living in the community setting.

A.27.17 An RMMR is available to all new residents on admission into a RACF. Generally, new residents should receive an RMMR as soon as possible after admission. Where a resident has a Comprehensive Medical assessment (CMA), the RMMR should be undertaken preferably after the results of the CMA are available to inform the RMMR.

A27.18 An RMMR is available to existing residents of a RACF where it is required in the opinion of the resident's medical practitioner because of a significant change in the resident's medical condition or medication regimen, for example (but not limit to):

(a) discharge from an acute care facility in the previous 4 weeks;
(b) significant changes to medication regimen in the last 3 months;
(c) change in medical conditions or abilities (including falls, cognition, physical function);
(d) prescription of medication with a narrow therapeutic index or requiring therapeutic monitoring;
(e) presentation of symptoms suggestive of an adverse drug reaction;
(f) sub-therapeutic response to treatment;
(g) suspected non-compliance or problems with managing drug related therapeutic devices; or
(h) at risk of inability to continue managing own medications (eg due to changes with dexterity, confusion or impaired sight).

A.27.19 The resident's medical practitioner may identify the potential need for an 'as required' RMMR for existing residents, including in the course of a consultation for another purpose. The potential need for an RMMR may also be identified by the reviewing pharmacist, supply pharmacist, Residential Aged Care Facility staff, the resident, the resident's carer or other members of the resident's health care team.

A.27.20 The medical practitioner should assess the clinical need for an RMMR from a quality use of medicines perspective with the resident as the focus, and initiate an RMMR if appropriate, in collaboration with the reviewing pharmacist.

A.27.21 The medical practitioner and reviewing pharmacist should agree on a preferred means for communicating issues and information relating to the provision of an RMMR service. This should include the method(s) of initiating the RMMR, exceptions to the post review discussion, and the preferred method of communication. This can be done on a facility basis rather than on a case by case basis.

Consent

A.27.22 A resident's consent should be obtained using normal procedures for obtaining consent for provision of a medical service, before proceeding with an RMMR.

'Usual GP'

A.27.23 An RMMR should generally be undertaken by the resident's 'usual GP'. This is broadly defined as the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months. GPs who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACFs as part of aged care panel arrangements, may also undertake RMMRs for residents as part of their services.

Content of a Residential Medication Management Review

A.27.24 An RMMR comprises all activities to be undertaken by the medical practitioner from the time the resident is identified as potentially needing a medication management review up to the development of a written medication management plan for the resident.

A.27.25 The activities to be undertaken by the medical practitioner as part of the RMMR include:

(a) discussing and seeking consent for an RMMR from the new or existing resident;
(b) initiating the RMMR and collaborating with the reviewing pharmacist regarding the pharmacy component of the review;
(c) providing input from the resident's Comprehensive Medical Assessment (CMA), or if a CMA has not been undertaken, providing relevant clinical information for the resident's RMMR and for the resident's records;
(d) participating in a post-review discussion (either face-to-face or by telephone) with the pharmacist (unless exceptions apply) to discuss the outcomes of the review including:
    - the findings of the pharmacist's review;
    - medication management strategies; and
    - means to ensure the strategies are implemented and reviewed, including any issues for implementation and normal follow-up;
(e) developing and/or revising the resident's Medication Management Plan after discussion with the reviewing pharmacist and finalising the plan after discussion with the resident;

(f) offering a copy of the Medication Management Plan to the resident (and/or their carer or representative if appropriate), providing a copy for the resident's records and for the nursing staff of the Residential Aged Care Facility, and discussing the plan with nursing staff if necessary.

A.27.26 An RMMR involves a post-review discussion between the medical practitioner and the reviewing pharmacist, unless agreed exceptions apply. The post-review discussion is not mandatory where:

(a) there are no recommended changes from the review;
(b) changes are minor in nature not requiring immediate discussion; or
(c) the pharmacist and medical practitioner agree that issues from the review should be considered in an Enhanced Primary Care (EPC) case conference.

Exceptions to mandatory discussion should be covered in the communications agreement between the medical practitioner and reviewing pharmacist.

The RMMR Medication Management Plan

A.27.27 The plan should identify the medication management goals and the proposed medication regimen for the resident. The preparation and/or revision of a written medication management plan following discussion with the resident includes:

(a) developing and/or revising a medication management plan and discussing it with the resident;
(b) offering a copy of the Medication Management Plan to the resident (and/or their carer or representative if appropriate), providing a copy for the resident's records and for the nursing staff of the Residential Aged Care Facility, and discussing the plan with nursing staff if necessary.

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

Medicare Benefits - Billing Arrangements

A.27.28 A maximum of one RMMR rebate is payable for each resident in any 12 month period, except where there has been a significant change in the resident's medical condition or medication regimen requiring a new RMMR.

A.27.29 Benefits are payable when all the activities of an RMMR have been completed. In some cases an RMMR may not be able to be completed due to circumstances beyond the control of the medical practitioner (eg, because the resident decides not to proceed with the RMMR or because of a change in the circumstances of the resident). In these cases the relevant MBS attendance item should be used in relation to any consultation undertaken with the resident.

A.27.30 An RMMR service covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the resident:

(a) any immediate action required to be done at the time of completing the RMMR, based on and as a direct result of information gathered in the RMMR, should be treated as part of the RMMR item;
(b) any subsequent follow up should be treated as a separate consultation item;
(c) an additional consultation in conjunction with completing the RMMR should not be undertaken unless it is clinically indicated that a problem must be treated immediately.

Combining RMMRs with other Medicare services

A.27.31 The RMMR item covers the consultation at which the RMMR service is initiated:

(a) if the consultation at which the RMMR is initiated, including discussion with resident and obtaining consent for the RMMR, is only for the purposes of initiating the review, only the RMMR item should be claimed;
(b) if the RMMR is initiated during the course of a consultation undertaken for another purpose, the other consultation may be claimed as a separate service and the RMMR service would also apply;
(c) if the medical practitioner determines that an RMMR is not necessary, the RMMR item does not apply; in this case, relevant consultation items should be used; and
(d) RMMRs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

A.28 Taking a cervical smear from a woman who is unscreened or significantly under-screened (Items 2497 - 2509 and 2598 - 2616)

A.28.1 The item numbers 2497, 2501, 2503, 2504, 2506, 2507, 2509, 2598, 2600, 2603, 2606, 2610, 2613 and 2616 should be used in place of the usual attendance item where as part of a consultation, a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last four years. These items should not be used in conjunction with item 10999.

A.28.2 The items apply only to women between the ages of 20 and 69 years inclusive who have a cervix, have had intercourse and have not had a cervical smear in the last four years.

A.28.3 When providing this service, the doctor must satisfy themselves that the woman has not had a cervical smear in the last four years by:

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

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

A.28.4 Women from the following groups are more likely than the general population to be unscreened or significantly underscreened - low socioeconomic status, culturally and linguistically diverse backgrounds, Indigenous communities, rural and remote areas and older women.

A.28.5 Vault smears are not eligible for items 2497 - 2509 and 2598 - 2616.
A.28.6 In addition to attracting a Medicare rebate, the use of these items will initiate a cervical screening incentive payment through the Practice Incentives Program (PIP).
A.28.7 A PIP cervical screening incentive is available for taking a cervical screen from women who have not been screened for four years. This incentive will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP. A further PIP incentive is paid to practices who reach target levels of cervical screening for their female patients aged 20-69 years inclusive. More detailed information on these incentives is available from the HIC PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip.

A.29 Completion of an annual cycle of care for patients with diabetes mellitus (Items 2517 - 2526, 2620 - 2635)
A.29.1 The item numbers 2517, 2518, 2521, 2522, 2525, 2526, and 2620, 2622, 2624, 2631, 2633, 2635, should be used in place of the usual attendance item when a consultation completes the minimum annual requirements of care for a patient with established diabetes mellitus.
A.29.2 The minimum requirements of care are:

Assess diabetes control by measuring HbA1c	At least once every year
Ensure that a comprehensive eye examination is carried out	At least once every two years
Measure weight and height and calculate BMI*	At least twice every cycle of care
Measure blood pressure	At least twice every cycle of care
Examine feet	At least twice every cycle of care
Measure total cholesterol, triglycerides and HDL cholesterol	At least once every year
Test for microalbuminuria	At least once every year
Provide self-care education	Patient education regarding diabetes management
Review diet	Reinforce information about appropriate dietary choices
Review levels of physical activity	Reinforce information about appropriate levels of physical activity
Check smoking status	Encourage cessation of smoking (if relevant)
Review of Medication	Medication review

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

A.29.3 These requirements are based on the general practice guidelines produced by the Royal Australian College of General Practitioners and Diabetes Australia (DA/RACGP, *Diabetes Management in General Practice,* 6th ed., 2000). Doctors using these items should familiarise themselves with these guidelines and with subsequent editions of these guidelines as they become available.
A.29.4 Use of these items certifies that the minimum annual cycle of care has been completed for a patient with established diabetes mellitus in accordance with the guidelines above.
A.29.5 These items should only be used once per year per patient of either A18 Subgroup 2 or A19 Subgroup 2. For example, if item 2517 is claimed for a patient then no other diabetes item in groups A18 or A19 can be used for this patient in the same year.
A.29.6 The requirements for claiming this item are the minimum needed to provide good care to a patient with diabetes. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications
and/or co-morbidities.
A.29.7 In addition to attracting a Medicare rebate, recording an annual completion of care cycle through the use of these items will initiate a diabetes incentive payment through the Practice Incentives Program (PIP).
A.29.8 A PIP diabetes incentive is available for completion of an annual cycle care for individual patients. This incentive is only paid once per year per patient. This incentive will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP. A further PIP incentive is paid to practices which reach target levels of care for their patients with diabetes . More detailed information on these incentives is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip.

A.30 Completion of the Asthma 3+ Visit Plan (Items 2546 - 2559, 2664 - 2677)
Minimum Requirements
A.30.1 The item numbers 2546, 2547, 2552, 2553, 2558, 2559 and 2664, 2666, 2668, 2673, 2675 and 2677 should be used in place of the usual attendance item when a consultation completes the requirements of the Asthma '3+Visit Plan'. The

Asthma initiative is for patients with moderate to severe asthma who in the opinion of the doctor could benefit from review, eg those whose asthma management could be improved. At a minimum the Asthma 3+ Visit Plan must include:

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

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

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

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

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

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

Assessment of Severity

A.30.2 Generally, patients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma:

- Symptoms on most days, OR
- Use of preventer medication, OR
- Bronchodilator use at least 3 times per week, OR
- Hospital attendance or admission following an acute exacerbation of asthma.

A.30.3 Where the general rule does not apply to a particular patient, the classification of severity described by the current edition of the National Asthma Council's *Asthma Management Handbook* can be used. The website address is:

www.NationalAsthma.org.au

A.30.4 Asthma 3+ Visit Plan

All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Asthma 3+ Visit Plan as per A30.1

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

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

The National Asthma Council recommendations for their 3+ Visit Plan are as follows:
(NOTE: This is provided as a guide only and each case should be addressed on the patient's individual clinical needs)

Engagement Visit

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

- Manage the issue that caused asthma to be discussed, e.g. worsening asthma symptoms, request for a script (ensure that you record the asthma-related activities).
- Introduce the concept of a 'partnership' for care: the **Asthma 3+ Visit Plan** and the reasons for review, and gain the patient's agreement.
- Give the **Asthma 3+ Visit Plan handout** to the patient.

Visit 1

- **New patient: ascertain status, including history, medication and management**. (Asthma Management Handbook p58-59)
- **Existing patient: assess present situation, including review of medical records and consolidation/collection of information on history, medication and management.** (p58-59)
- What do they know and what do they need to know? (knowledge) (p60-61 & p65-66)
- Advise patient about their local Asthma Foundation's 3+ Community Support Program – telephone 1800 645 130
- How do they feel about their asthma? (perception)
- What do they want from you, the GP? (expectations)
- Review medication devices technique and adherence. (p33, p55-57 & p62-63)
- Perform physical examination (including spirometry). (p4-7 & p36)
- Grade asthma severity and level of control. (p14-15 & p28)
- Consider 2 weeks of peak expiratory flow rate (PEFR) recording and charting. (p6-7 & p36)
- Is a change in medication required? (p22 & p32)
- Agree on a date for the next visit.

Visit 2 (approximately 2 weeks later)

- Review patient and his/her PEFR record.
- Perform spirometry (if not already done, or consider redoing). (p4-5 & p36)
- Complete written Asthma Action Plan or review existing plan. (p23-25 & p33-35)
- Further identify trigger factors: consider RAST, skin-prick tests (if not already done). (p17-19 & p37)
- Is a change in medication required? (p22 & p32)
- Check on, reinforce and expand education. (p65-66)
- Answer any questions.
- Agree on a date for the next visit.

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

- Assess progress.
- Review Asthma Action Plan.
- Review medication requirements according to asthma control.
- Discuss results of trigger factor tests (if applicable).
- Check on, reinforce and expand education.
- Answer any questions.

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

- Assess progress and asthma control, including spirometry.
- Review Asthma Action Plan and medication needs.
- Emphasise the benefits of adherence and assess medication device technique.
- Check on, reinforce and expand education.
- Answer any questions.

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

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

A.30.5 A PIP Asthma 3+ Visit Plan incentive is available for completing the minimum requirements of the Asthma 3+ Visit Plan as specified in clause A.30.1 above. This incentive will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP. More detailed information on this incentive is available from the HIC PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip.

A.31 Completion of the 3 Step Mental Health Process (Items 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708) Minimum Requirements

A.31.1 A PIP Mental Health incentive is available for providing the minimum requirements of the 3 Step Mental Health Process as specified in clause A.30.5 below. This incentive will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP or accredited. More detailed information on this incentive is available from the Medicare Australia PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip.

A.31.2 The item numbers 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708 can be accessed by practitioners who have completed the mental health Familiarisation Training and have the appropriate mental health skills as required by the General Practice Mental Health Standards Collaboration. Continued access to item numbers 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708 will be dependent on the medical practitioner meeting ongoing education requirements as determined by the General Practice Mental Health Standards Collaboration.

A.31.3 The item numbers 2574, 2575, 2577, 2578 and 2704, 2705, 2707,2708 should be used in place of the usual attendance item when a consultation completes the requirements of the 3 Step Mental Health Process.

A.31.4 Mental Health Disorder

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

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

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

A.31.5 Step Mental Health Process

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

- at least 2 consultations of more than 20 minutes each for a patient with an assessed mental health disorder;
- at least one of the consultations to have been a planned visit which must include a review step;
- assessment and formulation or diagnosis of the mental health disorder/s;
- provision of a written mental health plan and appropriate education to the patient and/or carer (with patient's agreement); and
- review of the patient's progress against the goals included in the mental health plan. This review to have been conducted a minimum of 4 weeks and a maximum of 6 months from the consultation in which the mental health plan was prepared.

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

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

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

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

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

A.31.6 *Step 1* ***Assessment***

An assessment of a patient must include:

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

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

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

Recommended Outcome Tools

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

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

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

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

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

A.31.7 *Step 2* ***Mental Health Plan***

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

If an assessment shows that the patient has a chronic medical condition and complex care needs it may be appropriate to involve other health professionals in the patient's care using the Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items. CDM items for GP Management Plans and Team Care Arrangements (see Items 721 - 731) may be claimed for such patients. If preparation of the mental health plan meets the conditions for a Team Care Arrangements item this item may be claimed. (See Note A22.15 – A22.23).

The development of a mental health plan must include:

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

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

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

A.31.8 *Step 3* ***Review of Mental Health Plan***
This step must occur a minimum of 4 weeks and a maximum of 6 months after the completion of step 2, the preparation of a mental health plan.

The review stage must include:

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

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

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

A.32 Provision of Focussed Psychological Strategies (Items 2721 – 2727)
A31.1 Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focused Psychological Strategies to a patient must be made in the context of a 3 Step Mental health Process.

Minimum Requirements
A32.2 All consultations providing Focussed Psychological Strategies must be rendered by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician). The service must be provided from a general practice that is either participating in the PIP or which is accredited.

A32.3 To ensure appropriate standards for the provision of Focussed Psychological Strategies, payment of Medicare rebates for these items will be limited to medical practitioners who are registered with Medicare Australia to participate in the *Better Outcomes in Mental Health Care* initiative; and who satisfy the General Practice Mental Health Standards Collaboration that they have the required higher level mental health skills for provision of the service.

A32.4 Continued access to item numbers 2721 - 2727 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

A32.5 Patients will in general be permitted to claim Medicare rebates for up to 6 services under these item numbers per year, however in certain circumstances relating to the patient's clinical status, a further 6 services can be claimed per 12 month period. After one group of six services, the practitioner managing the 3 Step Mental Health Process must conduct a review, and the conclusion of the review noted on the patient's record, before a further 6 services may be provided.

Out-of-Surgery Consultation

A32.6 It is expected that this service would be provided only for patients who are unable to attend the practice.

Specific Focussed Psychological Strategies

A32.7 A range of acceptable strategies has been approved for use by medical practitioners in this context. These are:

1. Psycho-education
(including motivational interviewing)

2. Cognitive-behavioural Therapy including:

- **Behavioural interventions**
  - Behaviour modification
  - Exposure techniques
  - Activity scheduling
- **Cognitive interventions**
  - Cognitive therapy

3 Relaxation strategies

- Progressive muscle relaxation
- Controlled breathing

4 Skills training

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

5. Interpersonal Therapy

Mental Health Disorder

A32.8 A mental health disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder – this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care:ICD - 10 Chapter V Primary Health Care Version.
These disorders include:

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

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

A.33 Telepsychiatry

A.33.1 **Telepsychiatry** is defined as electronic transmission of psychiatric consultations, advice or services in digital form from one location to another using a data communication link provided by a third party carrier, or carriers. It requires the providers to comply with the International Telecommunications Union Standards which cover all types of videoconferencing from massive bandwidth to internet use. If X-rays are required for a psychiatric consultation then the consultant psychiatrist must comply with the DICOM Standards.

A.33.2 **Education and Training**

Consultant Psychiatrists must have completed the *online Telepsychiatry Certification Module* available on the Royal Australian and New Zealand College of Psychiatrists (RANZCP) website. The RANZCP will keep a register of those consultant psychiatrists who have completed the *online Telepsychiatry Certification Module* and make it available to Medicare Australia for auditing purposes.

A.33.3 **Duration of Telepsychiatry Consultation**

For items 353 to 358 the **time** provides a range of options equal to those provided in items 300 to 308 to allow for the appropriate treatment depending on the requirements of the treatment plan.

A.33.4 **Number of Consultations in a Calendar Year**

Items 353 to 358 may only be claimed for up to a maximum of 12 consultations in aggregate for each patient in a calendar year. After every fourth telepsychiatry session the consultant psychiatrist must see the patient face-to-face. Items 364 to 370 may be claimed for up to a maximum of three face-to-face consultations for each patient per calendar year. Items 364 to 370 must be used to ensure that Medicare payments continue for further telepsychiatry consultations.
If the number of attendances in aggregate to which items 300 to 308 and items 353 to 370 apply exceeds 50 for a single patient in any calendar year, any further attendances on that patient in that calendar year would be covered by items 310 to 318.

A.33.5 **Documenting the Telepsychiatry Session**

For items 353 to 370 the psychiatrist must keep a record of the treatment provided during an episode of care via telepsychiatry sessions or face-to-face consultations and must convey this in writing to the referring medical practitioner after the first session and then, at a minimum, after every six consultations.

A.33.6 **Geographical**

Telepsychiatry items 353 to 358 are available for use when a consultant psychiatrist is located in the following Statistical Local Areas (SLAs):

M1 (Capital City Urban Centre)
M2 (Other Metropolitan Urban Centre population 100,000+)
R1 (Large Rural Centre population 25,000 to 99,000)
And a referred patient is located in:
R1 (Large Rural Centre population 25,000 to 99,000)
R2 (Small Rural Centre population 10,000 to 24,999)
R3 (Other Rural Area population <10,000)
Rem1 (Remote Centre population 5,000+)
Rem2 (Other remote area population <5,000+)

The consultant psychiatrist **cannot be located in the same SLA as the patient**. For example:

1. *A consultant psychiatrist conducts telepsychiatry consultations with a patient from his/her consulting rooms in Sydney CBD to the patient who is located in Albury, NSW. The consultant also visits Albury once a month as part of a "fly-in, fly-out" psychiatry service. When the consultant is in Albury and a consultation is required, he/she must conduct a face-to-face session with the patient. If 4 telepsychiatry session have already been conducted the consultant psychiatrist would claim an item in the ranges 364 to 370. If less than 4 telepsychiatry sessions have been conducted then the psychiatrist would use the current items 300 to 308.*
2. *If a consultant psychiatrist is located in Ballarat and the patient is also in Ballarat, the consultant would not be permitted to claim Medicare items for a consultation via telepsychiatry.*

A.33.7 **Formal Review**

A formal review mechanism will be developed to monitor the effectiveness of the Telepsychiatry items.

A.34 Attendances by Medical Practitioners who are Emergency Physicians (Items 501 to 536)

A34.1 Items 501 to 536 relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the ACEM.

A.34.2 Items 501 to 511 cover five categories of attendance based largely on the tasks undertaken in a recognised emergency medicine department of a private hospital by the practitioner during the attendance on the patient rather than simply on the time spent with the patient. The emergency department must be part of a hospital and this department must be licensed as an “emergency department” by the appropriate State government authority.

A.34.3 The attendances for items 501 to 515 are divided into five categories relating to the level of complexity, namely:

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

A34.4 To assist medical practitioners who are emergency physicians in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

LEVEL 1

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

LEVEL 2

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

LEVEL 3

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

LEVEL 4
This item covers more difficult problems requiring the taking of a "detailed history" and "detailed examination of one or more systems", with or without liaison with other health care professionals and subsequent discussion with the patient, his or her agent and/or relatives.

LEVEL 5
This item covers the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they are performed. These items also cover cases which need prolonged discussion. It involves the taking of a comprehensive history, comprehensive examination and involving medical decision making of high complexity.

A34.5 In relation to the time in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

A35 Prolonged Attendance by an Emergency Physician in Treatment of a Critical Condition (Items 519 to 536)

A35.1 The conditions to be met before services covered by items 519 to 536 attract benefits are:

(i) the patient must be in imminent danger of death ;

(ii) the times relate to the total time spent with a single patient, even if the time spent by the physician is not continuous.

A.36 Case Conferences by Consultant Psychiatrists (855 to 866)

A36.1 A range of new items has been introduced for case conferences by consultant psychiatrists in community settings and for discharge planning for hospital in-patients. These items are introduced to improve the effectiveness of psychiatric case conferences and make it easier for psychiatrists to work with general practitioners and allied health professionals, thereby ensuring better coordinated care for patients. Three new items (855, 857 and 858) cover the organisation of a community case conference and a further three (861, 864 and 866) cover the organisation of a discharge case conference. Where a consultant psychiatrist organises a case conference a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant psychiatrist and one other medical practitioner (other than a specialist or a consultant physician) are counted towards the minimum of three.

A.36.2 Items 855, 857, and 858 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal. Items 855, 857, and 858 do not apply to an in-patient of a hospital or day hospital facility.

A.36.3 For items 861, 864 and 866 a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility. Items 861, 864 or 866 are payable not more than once for each hospital admission.

A.36.4 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A.36.5 A case conference is a process by which a multidisciplinary team carries out the following activities:

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

A.36.6 For the purposes of items 855 to 866, a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient, and one of whom must be the patient's usual medical practitioner. The consultant psychiatrist and the medical practitioner are counted toward the minimum of three.

The patient's carer may be included as a member of the team (See A.36.8 below), in addition to the minimum of three health or care providers but do not count towards the minimum of three for Medicare purposes.

A.36.7 For the purposes of items 855 to 866 a consultant psychiatrist should generally be the consultant psychiatrist that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.36.8 For the purposes of A.36.5, "formal care provider" includes in addition to the consultant psychiatrist and a medical practitioner (other than a specialist or consultant physician):

- allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.
- home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

A.36.9 The involvement of a patient's carer, such as a friend or family member, in a multidisciplinary case conference team can provide significant benefits in terms of coordination of care for the patient. Where the patient has a carer, the consultant psychiatrist should consider inviting the carer to be an additional member of the multidisciplinary case conference team, with the patient's agreement and where the carer's input is likely to be relevant to the subject matter of the case conference. The involvement of the patient's carer is not counted towards the minimum of three members.
A.36.10 Where the patient's carer is not a member of the multidisciplinary team, the practitioner should involve the carer and provide information to the carer where appropriate and with the patient's agreement. However, the practitioner should take account of the impact of the tasks identified in the case conference on the capacity of the carer to provide support to the patient. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement.

Organisation of a case conference
A.36.11 Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:

- explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and
- recording the patient's agreement to the case conference; and
- recording the day on which the conference was held, and the times at which the conference started and ended; and
- recording the names of the participants; and
- recording the matters mentioned in A.36.4 and putting a copy of that record in the patient's medical records; and
- offering the patient (and the patient's carer, if appropriate and with the patient's agreement), and giving each other member of the team a summary of the conference; and
- discussing the outcomes of the case conference with the patient.

General requirements
A.36.12 In circumstances where the patient's usual medical practitioner, is not available to be a member of the case conference team, another medical practitioner known to the patient may be substituted.
A.36.13 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.
A.36.14 The case conference must be arranged in advance within a time frame that allows for all the participants to attend. The minimum three care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.
A.36.15 In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers;
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to or withheld from the other case conference team members; and
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable.
- Inform the patient of any additional costs he or she will incur. The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. (See General Notes 7.6)

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

LEVEL A			
PATIENTS	**FEE**	**85%**	**75%**
ONE	$36.40	$30.95	$27.30
TWO	$25.40	$21.60	$19.05
THREE	$21.75	$18.50	$16.35
FOUR	$19.90	$16.95	$14.95
FIVE	$18.80	$16.00	$14.10
SIX	$18.05	$15.35	$13.55
SEVEN+	$16.00	$13.60	$12.00

LEVEL B			
PATIENTS	**FEE**	**85%**	**75%**
ONE	$53.45	$45.45	$40.10
TWO	$42.45	$36.10	$31.85
THREE	$38.80	$33.00	$29.10
FOUR	$36.95	$31.45	$27.75
FIVE	$35.85	$30.50	$26.90
SIX	$35.10	$29.85	$26.35
SEVEN+	$33.05	$28.10	$24.80

LEVEL C			
PATIENTS	**FEE**	**85%**	**75%**
ONE	$81.70	$69.45	$61.30
TWO	$70.70	$60.10	$53.05
THREE	$67.05	$57.00	$50.30
FOUR	$65.20	$55.45	$48.90
FIVE	$64.10	$54.50	$48.10
SIX	$63.35	$53.85	$47.55
SEVEN+	$61.30	$52.15	$46.00

LEVEL D			
PATIENTS	**FEE**	**85%**	**75%**
ONE	$109.90	$93.45	$82.45
TWO	$98.90	$84.10	$74.20
THREE	$95.25	$81.00	$71.45
FOUR	$93.40	$79.40	$70.05
FIVE	$92.30	$78.50	$69.25
SIX	$91.55	$77.85	$68.70
SEVEN+	$89.50	$76.10	$67.15

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

BRIEF			
PATIENTS	**FEE**	**85%**	**75%**
ONE	$24.00	$20.40	$18.00
TWO	$16.25	$13.85	$12.20
THREE	$13.65	$11.65	$10.25
FOUR	$12.35	$10.50	$ 9.30
FIVE	$11.60	$ 9.90	$ 8.70
SIX	$11.10	$9.45	$ 8.35
SEVEN+	$9.20	$7.85	$ 6.90

STANDARD			
PATIENTS	**FEE**	**85%**	**75%**
ONE	$33.50	$28.50	$25.15
TWO	$24.75	$21.05	$18.60
THREE	$21.85	$18.60	$16.40
FOUR	$20.35	$17.30	$15.30
FIVE	$19.50	$16.60	$14.65
SIX	$18.90	$16.10	$14.20
SEVEN+	$16.70	$14.20	$12.55

LONG			
PATIENTS	**FEE**	**85%**	**75%**
ONE	$51.00	$43.35	$38.25
TWO	$43.25	$36.80	$32.45
THREE	$40.65	$34.60	$30.50
FOUR	$39.35	$33.45	$29.55
FIVE	$38.60	$32.85	$28.95
SIX	$38.10	$32.40	$28.60
SEVEN+	$36.20	$30.80	$27.15

PROLONGED			
PATIENTS	**FEE**	**85%**	**75%**
ONE	$73.00	$62.05	$54.75
TWO	$65.25	$55.50	$48.95
THREE	$62.65	$53.30	$47.00
FOUR	$61.35	$52.15	$46.05
FIVE	$60.60	$51.55	$45.45
SIX	$60.10	$51.10	$45.10
SEVEN+	$58.20	$49.50	$43.65

	GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	EMERGENCY ATTENDANCES - AFTER HOURS
1	**EMERGENCY ATTENDANCE AFTER HOURS** **(on not more than 1 patient on 1 occasion)** Professional attendance **AT A PLACE OTHER THAN CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance ***other than an attendance between 11pm and 7am,*** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.5 and A.10 of explanatory notes to this Category)* **Fee:** $110.20 **Benefit:** 100% = $110.20
2	Professional attendance **AT CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance ***other than an attendance between 11pm and 7am,*** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.5 and A.10 of explanatory notes to this Category)* **Fee:** $110.20 **Benefit:** 100% = $110.20
601	Professional attendance, at a place **OTHER THAN CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week ***between 11pm and 7am*** *(See para A.5 and A.10 of explanatory notes to this Category)* **Fee:** $129.80 **Benefit:** 100% = $129.80
602	Professional attendance, **AT CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance on any day of the week between ***11pm and 7am*** *(See para A.5 and A.10 of explanatory notes to this Category)* **Fee:** $129.80 **Benefit:** 100% = $129.80
	GENERAL PRACTITIONER ATTENDANCES
3	**LEVEL 'A'** Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.5 of explanatory notes to this Category)* **Fee:** $14.40 **Benefit:** 100% = $14.40
4	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 3, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.60 per patient
13	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 3, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.60 per patient
19	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient *(See para A.5 and A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 3, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.60 per patient

20	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 3, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.60 per patient
	LEVEL 'B' Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies
23	**SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.5 of explanatory notes to this Category)* **Fee:** $31.45 **Benefit:** 100% = $31.45
24	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.60 per patient
25	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.60 per patient
33	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient *(See para A.5 and A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.60 per patient
35	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.60 per patient
	LEVEL 'C' Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies
36	**SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.5 of explanatory notes to this Category)* **Fee:** $59.70 **Benefit:** 100% = $59.70
37	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.60 per patient
38	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.60 per patient

40	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient *(See para A.5 and A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.60 per patient
43	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.60 per patient
44	**LEVEL 'D'** Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.5 of explanatory notes to this Category)* **Fee:** $87.90 **Benefit:** 100% = $87.90
47	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.60 per patient
48	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.60 per patient
50	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient *(See para A.5 and A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.60 per patient
51	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.60 per patient

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

	CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient
87	**BRIEF CONSULTATION** of not more than 5 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient
89	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient
90	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient
91	**PROLONGED CONSULTATION** of more than 45 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) - each patient
92	**BRIEF CONSULTATION** of not more than 5 minutes duration *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient
93	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient
95	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient
96	**PROLONGED CONSULTATION** of more than 45 minutes duration *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient
	EMERGENCY ATTENDANCE - AFTER HOURS
	(on not more than 1 patient on 1 occasion)
97	Professional attendance after hours **AT A PLACE OTHER THAN CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment each attendance ***other than an attendance between 11pm and 7am,*** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.10 of explanatory notes to this Category)* **Fee:** $95.95 **Benefit:** 100% = $95.95
98	Professional attendance **AT CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance ***other than an attendance between 11pm and 7am*****,** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.10 of explanatory notes to this Category)* **Fee:** $95.95 **Benefit:** 100% = $95.95

	GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	EMERGENCY ATTENDANCE - AFTER HOURS
697	Professional attendance **AT A PLACE OTHER THAN CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week ***between 11pm and 7am*** *(See para A.10 of explanatory notes to this Category)* **Fee:** $113.75 **Benefit:** 100% = $113.75
698	Professional attendance **AT CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance on any day of the week between ***11pm and 7am*** *(See para A.10 of explanatory notes to this Category)* **Fee:** $113.75 **Benefit:** 100% = $113.75

	GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
104	**SPECIALIST, REFERRED CONSULTATION - SURGERY OR HOSPITAL** (Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her) **- INITIAL** attendance in a single course of treatment, not being a service to which item 106 applies **Fee:** $74.05 **Benefit:** 75% = $55.55 85% = $62.95
105	Each attendance **SUBSEQUENT** to the first in a single course of treatment **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
I 106	- **INITIAL SPECIALIST OPHTHALMOLOGIST ATTENDANCE** in a single course of treatment, being an attendance at which the sole service provided is refraction testing for the issue of a prescription for spectacles or contact lenses not being a service to which items 104 or 10801 to 10816 apply **Fee:** $61.45 **Benefit:** 75% = $46.10 85% = $52.25
107	**SPECIALIST, REFERRED CONSULTATION - HOME VISITS** (Professional attendance at a place other than consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her) **- INITIAL** attendance in a single course of treatment **Fee:** $108.60 **Benefit:** 75% = $81.45 85% = $92.35
108	Each attendance **SUBSEQUENT** to the first in a single course of treatment **Fee:** $68.70 **Benefit:** 75% = $51.55 85% = $58.40

GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - SURGERY OR HOSPITAL
(Professional attendance at consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)

- INITIAL attendance in a single course of treatment

110	**Fee:** $130.60	**Benefit:** 75% = $97.95	85% = $111.05

- Each attendance (other than a service to which item 119 applies) **SUBSEQUENT** to the first in a single course of treatment

116	**Fee:** $65.40	**Benefit:** 75% = $49.05	85% = $55.60

- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment
(See para A.11 of explanatory notes to this Category)

119	**Fee:** $37.15	**Benefit:** 75% = $27.90	85% = $31.60

CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - HOME VISITS
(Professional attendance at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)

- INITIAL attendance in a single course of treatment

122	**Fee:** $158.50	**Benefit:** 75% = $118.90	85% = $134.75

- Each attendance (other than a service to which item 131 applies) **SUBSEQUENT** to the first in a single course of treatment

128	**Fee:** $95.85	**Benefit:** 75% = $71.90	85% = $81.50

- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment
(See para A.11 of explanatory notes to this Category)

131	**Fee:** $69.00	**Benefit:** 75% = $51.75	85% = $58.65

	GROUP A5 - PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	PROLONGED PROFESSIONAL ATTENDANCES (Professional attendance (not being a service to which another item in this Category applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients)
160	- For a period of not less than 1 hour but less than 2 hours *(See para A.12 of explanatory notes to this Category)* **Fee:** $187.95 **Benefit:** 100% = $187.95
161	- For a period of not less than 2 hours but less than 3 hours *(See para A.12 of explanatory notes to this Category)* **Fee:** $313.20 **Benefit:** 100% = $313.20
162	- For a period of not less than 3 hours but less than 4 hours *(See para A.12 of explanatory notes to this Category)* **Fee:** $438.40 **Benefit:** 100% = $438.40
163	- For a period of not less than 4 hours but less than 5 hours *(See para A.12 of explanatory notes to this Category)* **Fee:** $563.80 **Benefit:** 100% = $563.80
164	- For a period of 5 hours or more *(See para A.12 of explanatory notes to this Category)* **Fee:** $626.50 **Benefit:** 100% = $626.50

	GROUP A6 - GROUP THERAPY
	FAMILY GROUP THERAPY (Professional attendance for the purpose of group therapy of not less than 1 hours duration given under the direct continuous supervision of a medical practitioner, other than a consultant physician in the practice of his or her specialty of psychiatry, involving members of a family and persons with close personal relationships with that family) - each group of 2 patients *(See para A.13 of explanatory notes to this Category)*
170	**Fee:** $99.75 **Benefit:** 100% = $99.75
	- each group of 3 patients *(See para A.13 of explanatory notes to this Category)*
171	**Fee:** $105.10 **Benefit:** 100% = $105.10
	- each group of 4 or more patients *(See para A.13 of explanatory notes to this Category)*
172	**Fee:** $127.90 **Benefit:** 100% = $127.90

	GROUP A7 - ACUPUNCTURE
173	ATTENDANCE at which ACUPUNCTURE is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed *(See para A.14 of explanatory notes to this Category)* **Fee:** $21.65 **Benefit:** 75% = $16.25 85% = $18.45
193	Professional attendance by a general practitioner who is a qualified medical acupuncturist, **at a place other than a hospital**, involving either: (i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; **OR** (ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies AND at which ACUPUNCTURE is performed by the general practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed *(See para A.5 and A.14 of explanatory notes to this Category)* **Fee:** $31.45 **Benefit:** 100% = $31.45
195	Professional attendance by a general practitioner who is a qualified medical acupuncturist, **on 1 or more patients at a hospital**, on one occasion, involving either: (i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; **OR** (ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies AND at which ACUPUNCTURE is performed by the general practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed *(See para A.5 and A.14 of explanatory notes to this Category)* **Derived Fee:** The fee for item 193, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus $1.60 per patient
197	Professional attendance by a general practitioner who is a qualified medical acupuncturist, **at a place other than a hospital**, involving either: (i) taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes; **OR** (ii) a professional attendance of at least 20 minutes but less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies AND at which ACUPUNCTURE is performed by the general practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed *(See para A.5 and A.14 of explanatory notes to this Category)* **Fee:** $59.70 **Benefit:** 100% = $59.70

ACUPUNCTURE		ACUPUNCTURE
	Professional attendance by a general practitioner who is a qualified medical acupuncturist, **at a place other than a hospital**, involving either: (i) taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems and lasting a least 40 minutes; **OR** (ii) a professional attendance of at least 40 minutes duration for implementation of a management plan AND at which ACUPUNCTURE is performed by the general practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed *(See para A.5 and A.14 of explanatory notes to this Category)*	
199	**Fee:** $87.90 **Benefit:** 100% = $87.90	

GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

CONSULTANT PSYCHIATRIST, REFERRED PATIENT ASSESSMENT AND MANAGEMENT

Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred for the provision of an assessment and management plan by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) where the attendance is initiated by that medical practitioner and where the consultant psychiatrist provides the referring medical practitioner with an assessment and management plan to be undertaken by that medical practitioner in general practice for the patient, where clinically appropriate.

An attendance of more than 45 minutes duration at consulting rooms during which:

- An outcome tool is used where clinically appropriate
- A mental state examination is conducted
- A psychiatric diagnosis is made
- The consultant psychiatrist decides that the patient can be appropriately managed by the referring medical practitioner without the need for ongoing treatment by the psychiatrist
- A 12 month management plan, appropriate to the diagnosis, is provided to the referring medical practitioner which must:
  a) comprehensively evaluate biological, psychological and social issues;
  b) address diagnostic psychiatric issues;
  c) make management recommendations addressing biological, psychological and social issues; and
  d) be provided to the medical practitioner within two weeks of completing the assessment of the patient.
- The diagnosis and management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement)
- The diagnosis and management plan is communicated in writing to the referring medical practitioner

Not being an attendance on a patient in respect of whom, in the preceeding 12 months, payment has been made under this item
(See para A.15 of explanatory notes to this Category)

291 **Fee:** $222.50 **Benefit:** 85% = $189.15

CONSULTANT PSYCHIATRIST, REVIEW OF REFERRED PATIENT ASSESSMENT AND MANAGEMENT

Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY to review a management plan previously prepared by that consultant psychiatrist for a patient and claimed under item 291, where the review is initiated by the referring medical practitioner practising in general practice.

An attendance of more than 30 minutes but not more than 45 minutes duration at consulting rooms where that attendance follows item 291 and during which:

- An outcome tool is used where clinically appropriate
- A mental state examination is conducted
- A psychiatric diagnosis is made
- A management plan provided under Item 291 is reviewed and revised
- The reviewed managment plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement)
- The reviewed management plan is communicated in writing to the referring medical practitioner

Being an attendance on a patient in respect of whom, in the preceeding 12 months, payment has been made under item 291, payable no more than once in any 12 month period
(See para A.15 of explanatory notes to this Category)

293 **Fee:** $139.70 **Benefit:** 85% = $118.75

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, CONSULTING ROOMS

(Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a medical practitioner)

- An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year.

300 **Fee:** $37.50 **Benefit:** 75% = $28.15 85% = $31.90

- An attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year.

302 **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65

- An attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year.

304 **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25

306	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. **Fee:** $151.45	**Benefit:** 75% = $113.60	85% = $128.75
308	- An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. **Fee:** $184.45	**Benefit:** 75% = $138.35	85% = $156.80
310	- An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $18.75	**Benefit:** 75% = $14.10	85% = $15.95
312	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $37.50	**Benefit:** 75% = $28.15	85% = $31.90
314	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $54.90	**Benefit:** 75% = $41.20	85% = $46.70
316	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $75.85	**Benefit:** 75% = $56.90	85% = $64.50
318	- An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $92.30	**Benefit:** 75% = $69.25	85% = $78.50
319	- An attendance of more than 45 minutes duration at consulting rooms, where the patient has: (i) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (ii) for persons 18 years and over, been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale where that attendance and any other attendance to which items 300 to 308 and items 353 to 370 apply do not exceed 160 attendances in a calendar year. *(See para A.16 of explanatory notes to this Category)* **Fee:** $151.45	**Benefit:** 75% = $113.60	85% = $128.75
	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, HOSPITAL (Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a medical practitioner)		
320	- An attendance of not more than 15 minutes duration at hospital. **Fee:** $37.50	**Benefit:** 75% = $28.15	85% = $31.90
322	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at hospital **Fee:** $74.85	**Benefit:** 75% = $56.15	85% = $63.65
324	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at hospital **Fee:** $109.70	**Benefit:** 75% = $82.30	85% = $93.25
326	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at hospital **Fee:** $151.45	**Benefit:** 75% = $113.60	85% = $128.75
328	- An attendance of more than 75 minutes duration at hospital **Fee:** $184.45	**Benefit:** 75% = $138.35	85% = $156.80

	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, HOME VISITS (Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a medical practitioner) - An attendance of not more than 15 minutes duration where that attendance is at a place other than consulting rooms or hospital
330	**Fee:** $68.80 **Benefit:** 75% = $51.60 85% = $58.50
	- An attendance of more than 15 minutes duration but not more than 30 minutes duration where that attendance is at a place other than consulting rooms or hospital
332	**Fee:** $107.95 **Benefit:** 75% = $81.00 85% = $91.80
	- An attendance of more than 30 minutes duration but not more than 45 minutes duration where that attendance is at a place other than consulting rooms or hospital
334	**Fee:** $149.70 **Benefit:** 75% = $112.30 85% = $127.25
	- An attendance of more than 45 minutes duration but not more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital
336	**Fee:** $181.15 **Benefit:** 75% = $135.90 85% = $154.00
	- An attendance of more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital
338	**Fee:** $215.95 **Benefit:** 75% = $162.00 85% = $183.60
	CONSULTANT PSYCHIATRIST - GROUP PSYCHOTHERAPY Group psychotherapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry where the patients are referred to him or her by a medical practitioner. - GROUP PSYCHOTHERAPY on a group of 2 to 9 unrelated patients OR FAMILY GROUP psychotherapy on a group of more than 3 patients, EACH PATIENT
342	**Fee:** $42.70 **Benefit:** 75% = $32.05 85% = $36.30
	- FAMILY GROUP PSYCHOTHERAPY on a group of 3 patients, EACH PATIENT
344	**Fee:** $56.70 **Benefit:** 75% = $42.55 85% = $48.20
	- FAMILY GROUP PSYCHOTHERAPY on a group of 2 patients, EACH PATIENT
346	**Fee:** $83.80 **Benefit:** 75% = $62.85 85% = $71.25
	CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY Professional attendance by a consultant physician in the practice of his or her recognised specialty of psychiatry, where the patient is referred to him or her by a medical practitioner involving an interview of a person other than the patient of not less than 20 minutes duration but less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient, where that interview is at consulting rooms, hospital or residential aged care facility *(See para A.17 of explanatory notes to this Category)*
348	**Fee:** $45.30 **Benefit:** 75% = $34.00 85% = $38.55
	- An attendance of not less than 45 minutes duration *(See para A.17 of explanatory notes to this Category)*
350	**Fee:** $101.85 **Benefit:** 75% = $76.40 85% = $86.60
	CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - IN THE COURSE OF CONTINUING MANAGEMENT OF A PATIENT Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a medical practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period *(See para A.17 of explanatory notes to this Category)*
352	**Fee:** $45.30 **Benefit:** 75% = $34.00 85% = $38.55

	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION VIA TELEPSYCHIATRY FOR ASSESSMENT, DIAGNOSIS AND TREATMENT A telepsychiatry consultation by a consultant physician in the practice of his or her specialty of PSYCHIATRY (not being an attendance to which items 300 to 319 apply), where: -the patient is referred to him or her by a medical practitioner for assessment, diagnosis and/or treatment, -that consultation and any other consultation to which items 353 to 358 apply, have not exceeded 12 consultations in a calendar year, -a minimum of one face-to-face consultation (items 364 to 370) is conducted with the patient after every fourth telepsychiatry consultation, and -any other attendance to which items 300 to 308 and 353 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. A telepsychiatry consultation of not more than 15 minutes duration. *(See para A.33 of explanatory notes to this Category)*		
353	**Fee:** $43.10	**Benefit:** 75% = $32.35	85% = $36.65
	A telepsychiatry consultation of more than 15 minutes duration but not more than 30 minutes duration. *(See para A.33 of explanatory notes to this Category)*		
355	**Fee:** $86.10	**Benefit:** 75% = $64.60	85% = $73.20
	A telepsychiatry consultation of more than 30 minutes duration but not more than 45 minutes duration. *(See para A.33 of explanatory notes to this Category)*		
356	**Fee:** $126.25	**Benefit:** 75% = $94.70	85% = $107.35
	A telepsychiatry consultation of more than 45 minutes duration but not more than 75 minutes duration *(See para A.33 of explanatory notes to this Category)*		
357	**Fee:** $174.20	**Benefit:** 75% = $130.65	85% = $148.10
	A telepsychiatry consultation of more than 75 minutes duration *(See para A.33 of explanatory notes to this Category)*		
358	**Fee:** $212.20	**Benefit:** 75% = $159.15	85% = $180.40
	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND TREATMENT FOLLOWING TELEPSYCHIATRY Professional attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, where: -the patient is referred to him or her by a medical practitioner, -that attendance occurs following four telepsychiatry consultations (items 353 to 358), - where that attendance and any other attendance to which items 364 to 370 apply does not exceed three consultations per patient in a calendar year. -any other attendance to which items 300 to 308 and 353 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. These items may only be used after every fourth telepsychiatry consultation conducted in accordance with items 353 to 358. A face-to-face attendance of not more than 15 minutes duration. *(See para A.33 of explanatory notes to this Category)*		
364	**Fee:** $37.50	**Benefit:** 75% = $28.15	85% = $31.90
	A face-to-face attendance of more than 15 minutes duration but not more than 30 minutes duration *(See para A.33 of explanatory notes to this Category)*		
366	**Fee:** $74.85	**Benefit:** 75% = $56.15	85% = $63.65
	A face-to-face attendance of more than 30 minutes duration but not more than 45 minutes duration. *(See para A.33 of explanatory notes to this Category)*		
367	**Fee:** $109.70	**Benefit:** 75% = $82.30	85% = $93.25
	A face-to-face attendance of more than 45 minutes duration but not more than 75 minutes duration *(See para A.33 of explanatory notes to this Category)*		
369	**Fee:** $151.45	**Benefit:** 75% = $113.60	85% = $128.75
	A face-to-face attendance of more than 75 minutes duration. *(See para A.33 of explanatory notes to this Category)*		
370	**Fee:** $184.45	**Benefit:** 75% = $138.35	85% = $156.80

	GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
385	**CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - SURGERY OR HOSPITAL** (Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner) **-INITIAL** attendance in a single course of treatment *(See para A.18 of explanatory notes to this Category)* **Fee:** $74.05 **Benefit:** 75% = $55.55 85% = $62.95
386	- Each attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.18 of explanatory notes to this Category)* **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
387	**CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - HOME VISITS** (Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner) **- INITIAL** attendance in a single course of treatment *(See para A.18 of explanatory notes to this Category)* **Fee:** $108.60 **Benefit:** 75% = $81.45 85% = $92.35
388	- Each attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.18 of explanatory notes to this Category)* **Fee:** $68.70 **Benefit:** 75% = $51.55 85% = $58.40

GROUP A13 - PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

PUBLIC HEALTH PHYSICIAN ATTENDANCES - SURGERY

(Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)

410	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management *(See para A.24 of explanatory notes to this Category)* **Fee:** $14.40	**Benefit:** 75% = $10.80	85% = $12.25
411	- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR an attendance of less than 20 minutes duration involving components of a service to which item 412 applies *(See para A.24 of explanatory notes to this Category)* **Fee:** $31.45	**Benefit:** 75% = $23.60	85% = $26.75
412	- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 413 applies *(See para A.24 of explanatory notes to this Category)* **Fee:** $59.70	**Benefit:** 75% = $44.80	85% = $50.75
413	- Attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR an attendance of at least 40 minutes duration for implementation of a management plan *(See para A.24 of explanatory notes to this Category)* **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75

PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS

(Professional attendance at other than consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)

414	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management *(See para A.24 of explanatory notes to this Category)* **Derived Fee:** The fee for item 410, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 410 plus $1.60 per patient
415	- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR an attendance of less than 20 minutes duration involving components of a service to which item 416 applies *(See para A.24 of explanatory notes to this Category)* **Derived Fee:** The fee for item 411, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 411 plus $1.60 per patient
416	- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 417 applies *(See para A.24 of explanatory notes to this Category)* **Derived Fee:** The fee for item 412, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 412 plus $1.60 per patient
417	- Attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR an attendance of at least 40 minutes duration for implementation of a management plan *(See para A.24 of explanatory notes to this Category)* **Derived Fee:** The fee for item 413, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 413 plus $1.60 per patient

GROUP A16 - MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

SUBGROUP 1 - SURGERY CONSULTATIONS

MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES - SURGERY

LEVEL 1

Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine

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

(See para A.26 of explanatory notes to this Category)

444 **Fee:** $14.40 **Benefit:** 75% = $10.80 85% = $12.25

LEVEL 2

Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine

- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, or an attendance of less than 20 minutes duration involving components of a service to which item 446 applies

(See para A.26 of explanatory notes to this Category)

445 **Fee:** $31.45 **Benefit:** 75% = $23.60 85% = $26.75

LEVEL 3

Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine

- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, or an attendance of less than 40 minutes duration involving components of a service to which item 447 applies

(See para A.26 of explanatory notes to this Category)

446 **Fee:** $59.70 **Benefit:** 75% = $44.80 85% = $50.75

LEVEL 4

Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine

- Attendance involving taking an exhaustive history, an comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, or an attendance of at least 40 minutes duration for implementation of a management plan

(See para A.26 of explanatory notes to this Category)

447 **Fee:** $87.90 **Benefit:** 75% = $65.95 85% = $74.75

SUBGROUP 2 - EMERGENCY ATTENDANCES - AFTER HOURS

MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES - EMERGENCY AFTER HOURS

Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine

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

(See para A.10 of explanatory notes to this Category)

448 **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00

Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine

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

(See para A.10 of explanatory notes to this Category)

449 **Fee:** $119.60 **Benefit:** 75% = $89.70 85% = $101.70

GROUP A21 - MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

SUBGROUP 1 - CONSULTATIONS

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 1

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

Attendance for the unscheduled evaluation and management of a patient requiring the taking of a problem focussed history, limited examination, diagnosis and initiation of appropriate treatment interventions involving straightforward medical decision making.

(See para A.34 of explanatory notes to this Category)

501 **Fee:** $14.40 **Benefit:** 75% = $10.80 85% = $12.25

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 2

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

Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems and the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of low complexity.

(See para A.34 of explanatory notes to this Category)

503 **Fee:** $31.45 **Benefit:** 75% = $23.60 85% = $26.75

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 3

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

Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of moderate complexity.

(See para A.34 of explanatory notes to this Category)

507 **Fee:** $59.70 **Benefit:** 75% = $44.80 85% = $50.75

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 4

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

Attendance for the unscheduled evaluation and management of a patient requiring the taking of a detailed history, detailed examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of moderate complexity.

(See para A.34 of explanatory notes to this Category)

511 **Fee:** $87.90 **Benefit:** 75% = $65.95 85% = $74.75

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 5

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

Attendance for the unscheduled evaluation and management of a patient requiring the taking of a comprehensive history, comprehensive examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of high complexity.

(See para A.34 of explanatory notes to this Category)

515 **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60

	SUBGROUP 2 - PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
	MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine Attendance for emergency evaluation of a critically ill patient with an immediately life threatening problem requiring immediate and rapid assessment, initiation of resuscitation and electronic vital signs monitoring, comprehensive history and evaluation whilst undertaking resuscitative measures, ordering and evaluation of appropriate investigations, transitional evaluation and monitoring, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives prior to admission to an in-patient hospital bed -For a period of not less than 30 minutes but less than 1 hour of total physician time spent with each patient *(See para A.35 of explanatory notes to this Category)*
519	**Fee:** $93.95 **Benefit:** 75% = $70.50 85% = $79.90
	-For a period of not less than 1 hour but less than 2 hours of total physician time spent with each patient *(See para A.35 of explanatory notes to this Category)*
520	**Fee:** $187.95 **Benefit:** 75% = $141.00 85% = $159.80
	-For a period of not less than 2 hours but less than 3 hours of total physician time spent with each patient *(See para A.35 of explanatory notes to this Category)*
530	**Fee:** $313.20 **Benefit:** 75% = $234.90 85% = $266.25
	-For a period of not less than 3 hours but less than 4 hours of total physician time spent with each patient. *(See para A.35 of explanatory notes to this Category)*
532	**Fee:** $438.40 **Benefit:** 75% = $328.80 85% = $376.90
	-For a period of not less than 4 hours but less than 5 hours of total physician time spent with each patient *(See para A.35 of explanatory notes to this Category)*
534	**Fee:** $563.80 **Benefit:** 75% = $422.85 85% = $502.30
	-For a period of 5 hours or more of total physician time spent with each patient. *(See para A.35 of explanatory notes to this Category)*
536	**Fee:** $626.50 **Benefit:** 75% = $469.90 85% = $565.00

	GROUP A14 - HEALTH ASSESSMENTS
700	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient who is **at least 75 years old** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 702, 704 or 706** *(See para A.21 of explanatory notes to this Category)* **Fee:** $164.00 **Benefit:** 100% = $164.00
702	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY** for a health assessment - of a patient who is **at least 75 years old** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700**, **704 or 706** *(See para A.21 of explanatory notes to this Category)* **Fee:** $232.00 **Benefit:** 100% = $232.00
704	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient who is **at least 55 years old and of Aboriginal or Torres Strait Islander descent** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 702 or 706** *(See para A.21 of explanatory notes to this Category)* **Fee:** $164.00 **Benefit:** 100% = $164.00
706	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY,** for a health assessment - of a patient who is **at least 55 years old and of Aboriginal or Torres Strait Islander descent** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 702 or 704** *(See para A.21 of explanatory notes to this Category)* **Fee:** $232.00 **Benefit:** 100% = $232.00
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 at least 15 years old and less than 55 years old - 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 *(See para A.21 of explanatory notes to this Category)* **Fee:** $195.50 **Benefit:** 100% = $195.50
712	Attendance by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) **AT A RESIDENTIAL AGED CARE FACILITY OR AT CONSULTING ROOMS** for a Comprehensive Medical Assessment (CMA) of a permanent resident of a residential aged care facility - not being a CMA of a resident in respect of whom, in the preceding 12 months, a payment has been made under this item. Benefits under this item are payable in respect of one CMA for new residents on admission to a Residential Aged Care Facility and for continuing residents on an as required basis, with a maximum of one CMA for a resident in any twelve month period. *(See para A.21 of explanatory notes to this Category)* **Fee:** $183.80 **Benefit:** 100% = $183.80

GROUP A15 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES

SUBGROUP 1 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS

721

PREPARATION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) of a **GP MANAGEMENT PLAN** for a patient (not being a service associated with a service to which **items 734 to 779** apply).

A rebate will not be paid within twelve months of a previous claim for the same item or former item 720, or within three months of a claim for items 725, 727, 729 or 731, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new GP Management Plan.

(See para A.22 of explanatory notes to this Category)

Fee: $122.40 **Benefit:** 75% = $91.80 100% = $122.40

723

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to **COORDINATE** the development of **TEAM CARE ARRANGEMENTS** for a patient (not being a service associated with a service to which **items 734 to 779** apply).

A rebate will not be paid within twelve months of a previous claim for the same item or former item 720, or within three months of a claim for item 727, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the coordination of new Team Care Arrangements.

(See para A.22 of explanatory notes to this Category)

Fee: $96.90 **Benefit:** 75% = $72.70 100% = $96.90

725

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to **REVIEW:**

(a) a **GP MANAGEMENT PLAN** prepared by that medical practitioner (or an associated medical practitioner) to which item 721 applies; or

(b) a multidisciplinary community care plan to which former item 720 applied, or a multidisciplinary discharge care plan to which former item 722 applied, prepared by that medical practitioner (or an associated medical practitioner); (not being a service associated with a service to which **items 734 to 779** apply).

A rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for item 721, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new review of a GP Management Plan.

(See para A.22 of explanatory notes to this Category)

Fee: $61.20 **Benefit:** 75% = $45.90 100% = $61.20

727

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to **COORDINATE** a **REVIEW** of

(a) **TEAM CARE ARRANGEMENTS** coordinated by that medical practitioner (or an associated medical practitioner) to which item 723 applies; or

(b) a multidisciplinary community care plan to which former item 720 applied or a multidisciplinary discharge care plan to which former item 722 applied, prepared by that medical practitioner (or an associated medical practitioner); (not being a service associated with a service to which **items 734 to 779** apply).

A rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for item 723, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the coordination of a new review of Team Care Arrangements.

(See para A.22 of explanatory notes to this Category)

Fee: $61.20 **Benefit:** 75% = $45.90 100% = $61.20

729

CONTRIBUTION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to a multidisciplinary care plan prepared by another provider or to a **REVIEW** of a multidisciplinary care plan prepared by another provider (not being a service associated with a service to which **items 734 to 779** apply).

A rebate will not be paid within twelve months of a claim by the same practitioner for item 721 or 723, within three months of a claim for the same item or within three months of a claim for item 725, former item 726, item 727, former item 728 or item 731, except where there has been a significant change in the patient's clinical condition or care circumstances that requires a new contribution to the multidisciplinary care plan.

(See para A.22 of explanatory notes to this Category)

Fee: $42.50 **Benefit:** 100% = $42.50

	CONTRIBUTION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to: (a) a multidisciplinary care plan for a patient in **A RESIDENTIAL AGED CARE FACILITY**, prepared by that facility, or to a **REVIEW** of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider; (not being a service associated with a service to which **items 734 to 779** apply). A rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for item 721, 723, 725, 727, 729 or former item 730, except where there has been a significant change in the patient's clinical condition or care circumstances that requires a new contribution to the multidisciplinary care plan. *(See para A.22 of explanatory notes to this Category)*
731	**Fee:** $42.50 **Benefit:** 100% = $42.50
	SUBGROUP 2 - CASE CONFERENCES
	CASE CONFERENCE - MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN) Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.23 of explanatory notes to this Category)*
734	**Fee:** $82.05 **Benefit:** 100% = $82.05
	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.23 of explanatory notes to this Category)*
736	**Fee:** $123.05 **Benefit:** 100% = $123.05
	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.23 of explanatory notes to this Category)*
738	**Fee:** $164.00 **Benefit:** 100% = $164.00
	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.23 of explanatory notes to this Category)*
740	**Fee:** $82.05 **Benefit:** 100% = $82.05
	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.23 of explanatory notes to this Category)*
742	**Fee:** $123.05 **Benefit:** 100% = $123.05
	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.23 of explanatory notes to this Category)*
744	**Fee:** $164.00 **Benefit:** 100% = $164.00
	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.23 of explanatory notes to this Category)*
746	**Fee:** $82.05 **Benefit:** 75% = $61.55 85% = $69.75

CHRONIC DISEASE MANAGEMENT			CASE CONFERENCES
749	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.23 of explanatory notes to this Category)* **Fee:** $123.05	**Benefit:** 75% = $92.30	85% = $104.60
757	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.23 of explanatory notes to this Category)* **Fee:** $164.00	**Benefit:** 75% = $123.00	85% = $139.40
759	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.23 of explanatory notes to this Category)* **Fee:** $58.55	**Benefit:** 100% = $58.55	
762	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.23 of explanatory notes to this Category)* **Fee:** $93.75	**Benefit:** 100% = $93.75	
765	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.23 of explanatory notes to this Category)* **Fee:** $128.85	**Benefit:** 100% = $128.85	
768	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.23 of explanatory notes to this Category)* **Fee:** $58.55	**Benefit:** 75% = $43.95	85% = $49.80
771	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.23 of explanatory notes to this Category)* **Fee:** $93.75	**Benefit:** 75% = $70.35	85% = $79.70
773	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.23 of explanatory notes to this Category)* **Fee:** $128.85	**Benefit:** 75% = $96.65	85% = $109.55
775	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.23 of explanatory notes to this Category)* **Fee:** $58.55	**Benefit:** 100% = $58.55	

CHRONIC DISEASE MANAGEMENT				CASE CONFERENCES
778	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.23 of explanatory notes to this Category)* **Fee:** $93.75	**Benefit:** 100% = $93.75		
779	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.23 of explanatory notes to this Category)* **Fee:** $128.85	**Benefit:** 100% = $128.85		
	CASE CONFERENCE - CONSULTANT PHYSICIAN			
820	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $120.35	**Benefit:** 75% = $90.30	85% = $102.30	
822	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $180.60	**Benefit:** 75% = $135.45	85% = $153.55	
823	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $240.70	**Benefit:** 75% = $180.55	85% = $204.60	
825	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of a least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $86.50	**Benefit:** 75% = $64.90	85% = $73.55	
826	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $137.90	**Benefit:** 75% = $103.45	85% = $117.25	
828	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $189.30	**Benefit:** 75% = $142.00	85% = $160.95	
830	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $120.35	**Benefit:** 75% = $90.30	85% = $102.30	

832	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $180.60	**Benefit:** 75% = $135.45	85% = $153.55
834	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $240.70	**Benefit:** 75% = $180.55	85% = $204.60
835	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $86.50	**Benefit:** 75% = $64.90	85% = $73.55
837	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $137.90	**Benefit:** 75% = $103.45	85% = $117.25
838	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) *(See para A.25 of explanatory notes to this Category)* **Fee:** $189.30	**Benefit:** 75% = $142.00	85% = $160.95
855	**CASE CONFERENCE - CONSULTANT PSYCHIATRIST** Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE** of at least 15 minutes, but less than 30 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.36 of explanatory notes to this Category)* **Fee:** $120.35	**Benefit:** 75% = $90.30	85% = $102.30
857	Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE** of at least 30 minutes, but less than 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.36 of explanatory notes to this Category)* **Fee:** $180.60	**Benefit:** 75% = $135.45	85% = $153.55
858	Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE** of at least 45 minutes with a multidisciplinary team of at least two other formal care providers, of different disciplines *(See para A.36 of explanatory notes to this Category)* **Fee:** $240.70	**Benefit:** 75% = $180.55	85% = $204.60
861	**CASE CONFERENCE - CONSULTANT PSYCHIATRIST** Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, of at least 15 minutes, but less than 30 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.36 of explanatory notes to this Category)* **Fee:** $120.35	**Benefit:** 75% = $90.30	85% = $102.30
864	Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, of at least 30 minutes, but less than 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.36 of explanatory notes to this Category)* **Fee:** $180.60	**Benefit:** 75% = $135.45	85% = $153.55

CHRONIC DISEASE MANAGEMENT		CASE CONFERENCES
866	Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, of at least 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.36 of explanatory notes to this Category)* **Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60	

ATTENDANCE		ATTENDANCE
	GROUP A17 - DOMICILIARY MEDICATION MANAGEMENT REVIEW	
900	Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a **Domiciliary Medication Management Review (DMMR)** for patients living in the community setting, where the medical practitioner: - assesses a patient's medication management needs, and following that assessment, refers the patient to a community pharmacy for a DMMR, and provides relevant clinical information required for the review, with the patient's consent; and - discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and - develops a written medication management plan following discussion with the patient. Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR. *(See para A.27 of explanatory notes to this Category)* **Fee:** $131.35 **Benefit:** 100% = $131.35	
I 903	Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a collaborative **Residential Medication Management Review (RMMR)** for a permanent **resident** of a residential aged care facility, where the medical practitioner: - discusses and seeks consent for an RMMR from the new or existing resident; - collaborates with the reviewing pharmacist regarding the pharmacy component of the review; - provides input from the resident's Comprehensive Medical Assessment (CMA), or if a CMA has not been undertaken, provides relevant clinical information for the resident's RMMR; - discusses findings of the pharmacist review and proposed medication management strategies with the reviewing pharmacist (unless exceptions apply); - develops and/or revises a written medication plan for the resident; and - consults with the resident to discuss the medication mangement plan and its implementation. Benefits under this item are payable for one RMMR service for new residents on admission to a Residential Aged Care Facility and for continuing residents on an as required basis, with a maximum of one RMMR for a resident in any 12 month period, except where there has been a significant change in medical condition or medication regimen requiring a new RMMR. *(See para A.27 of explanatory notes to this Category)* **Fee:** $89.95 **Benefit:** 100% = $89.95	

	GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS
	SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED WOMAN
2497	**LEVEL 'A'** Professional attendance involving taking a short patient history and, if required, limited examination and management AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999 **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.28 of explanatory notes to this Category)* **Fee:** $14.40 **Benefit:** 100% = $14.40
2501	**LEVEL 'B'** Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies; AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.28 of explanatory notes to this Category)* **Fee:** $31.45 **Benefit:** 100% = $31.45
2503	**OUT-OF-SURGERY CONSULTATION** (Professional attendance at a place other than consulting rooms). This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2501, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2501 plus $1.60 per patient
2504	**LEVEL 'C'** Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies; AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.28 of explanatory notes to this Category)* **Fee:** $59.70 **Benefit:** 100% = $59.70
2506	**OUT-OF-SURGERY CONSULTATION** (Professional attendance at a place other than consulting rooms). This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2504, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2504 plus $1.60 per patient

	LEVEL 'D' Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan; AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.28 of explanatory notes to this Category)*
2507	**Fee:** $87.90 **Benefit:** 100% = $87.90
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms). This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)*
2509	**Derived Fee:** The fee for item 2507, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2507 plus $1.60 per patient

	SUBGROUP 2 - COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH DIABETES MELLITUS
	The minimum requirements of care needed to be assessed to complete an annual cycle of care for patients with diabetes mellitus are: - Assess diabetes control by measuring HbA_{1c} — At least once every year - Ensure that a comprehensive eye examination is carried out: — At least once every two years - Measure weight and height and calculate BMI*: — At least twice every cycle of care - Measure blood pressure: — At least twice every cycle of care - Examine feet: — At least twice every cycle of care - Measure total cholesterol, triglycerides and HDL cholesterol: — At least once every year - Test for microalbuminuria: — At least once every year - Provide self-care education: — Patient education regarding diabetes management - Review diet: — Reinforce information about appropriate dietary choices - Review levels of physical activity: — Reinforce information about appropriate levels of physical activity - Check smoking status: — Encourage cessation of smoking (if relevant) - Review of medication: — Medication review * Initial visit: measure height and weight and calculate BMI as part of the initial patient assessment. Subsequent visits: measure weight. **LEVEL 'B'** Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies; AND which completes the requirements for a full year of care of a patient with established diabetes mellitus **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.29 of explanatory notes to this Category)*
I 2517	**Fee:** $31.45 **Benefit:** 100% = $31.45
2518	**OUT-OF-SURGERY CONSULTATION** (Professional attendance at a place other than consulting rooms) *(See para A.29 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2517, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2517 plus $1.60 per patient
	LEVEL 'C' Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies; AND which completes the requirements for a full year of care of a patient with established diabetes mellitus **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.29 of explanatory notes to this Category)*
2521	**Fee:** $59.70 **Benefit:** 100% = $59.70
2522	**OUT-OF-SURGERY CONSULTATION** (Professional attendance at a place other than consulting rooms) *(See para A.29 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2521, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus $1.60 per patient

	LEVEL 'D' Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan; AND which completes the requirements for a full year of care of a patient with established diabetes mellitus **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.29 of explanatory notes to this Category)*
2525	**Fee:** $87.90 **Benefit:** 100% = $87.90
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) *(See para A.29 of explanatory notes to this Category)*
2526	**Derived Fee:** The fee for item 2525, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus $1.60 per patient
	SUBGROUP 3 - COMPLETION OF THE ASTHMA 3+ VISIT PLAN
	Note: Benefits are payable for only one service included in Subgroup 3 or A19, Subgroup 3 in a 12-month period, unless a further Asthma 3+ Visit Plan is clinically indicated. At a minimum the Asthma 3+ Visit Plan must include: - documented diagnosis and assessment of severity - at least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with **moderate to severe** asthma - review of the patient's use of asthma related medication - planned recalls for at least two of these consultations - provision of a written asthma action plan and self-management education to the patient, (if the patient is unable to use a written action plan, alternative patient education may be provided and documented in the medical record). - review of asthma action plan **LEVEL 'B'** Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies; AND which completes the minimum requirements of the Asthma 3+ Visit Plan. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.30 of explanatory notes to this Category)*
2546	**Fee:** $31.45 **Benefit:** 100% = $31.45
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) *(See para A.30 of explanatory notes to this Category)*
2547	**Derived Fee:** The fee for item 2546, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2546 plus $1.60 per patient
	LEVEL 'C' Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies; AND which completes the minimum requirements of the Asthma 3+ Visit Plan. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.30 of explanatory notes to this Category)*
2552	**Fee:** $59.70 **Benefit:** 100% = $59.70
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) *(See para A.30 of explanatory notes to this Category)*
2553	**Derived Fee:** The fee for item 2552, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2552 plus $1.60 per patient

	LEVEL 'D' Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan; AND which completes the minimum requirements of the Asthma 3+ Visit Plan. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.30 of explanatory notes to this Category)*
2558	**Fee:** $87.90 **Benefit:** 100% = $87.90
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) *(See para A.30 of explanatory notes to this Category)*
2559	**Derived Fee:** The fee or item 2558, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2558 plus $1.60 per patient

SUBGROUP 4 - COMPLETION OF THE 3 STEP MENTAL HEALTH PROCESS

Note: Benefits included in Subgroup 4, A18 or A19, are payable for one 3 Step Mental Health Process per patient only in a 12-month period, unless a further 3 Step Mental Health Process is clinically indicated.

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

- at least 2 consultations of more than twenty minutes each for a patient with an assessed mental health disorder;
- at least one of the consultations to have been a planned visit which must include the review step;
- an assessment and formulation or diagnosis of the mental health disorder/s;
- provision of a written mental health plan and appropriate education to the patient and/or the carer (with the patient's agreement);
- a review of the patient's progress against the goals included in the mental health plan. This review to have been conducted a minimum of 4 weeks and a maximum of 6 months from the consultation in which the mental health plan was prepared; and
- utilising an outcome tool in the assessment and review stages except where considered clinically inappropriate.

The 3 Step Mental Health Process can only be provided by a general practitioner, who practices in general practice and has been notified to the HIC as having the required credentials.

LEVEL C

Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies;

AND which completes the requirements of the 3 Step Mental Health Process.

SURGERY CONSULTATION
(Professional attendance at consulting rooms)
(See para A.31 of explanatory notes to this Category)

I 2574 **Fee:** $59.70 **Benefit:** 100% = $59.70

OUT-OF-SURGERY CONSULTATION
(Professional attendance at a place other than consulting rooms)
(See para A.31 of explanatory notes to this Category)

2575 **Derived Fee:** The fee for item 2574, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2574 plus $1.60 per patient.

LEVEL 'D'

Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan;

AND which completes the requirements of the 3 Step Mental Health Process.

SURGERY CONSULTATION
(Professional attendance at consulting rooms)
(See para A.31 of explanatory notes to this Category)

2577 **Fee:** $87.90 **Benefit:** 100% = $87.90

OUT-OF-SURGERY CONSULTATION
(Professional attendance at a place other than consulting rooms)
(See para A.31 of explanatory notes to this Category)

2578 **Derived Fee:** The fee for item 2577, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2578 plus $1.60 per patient.

	GROUP A19 - OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES
	SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED WOMAN
2598	**SURGERY CONSULTATIONS** (Professional attendance at consulting rooms) **BRIEF CONSULTATION** of not more than 5 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999 *(See para A.28 of explanatory notes to this Category)* **Fee:** $11.00 **Benefit:** 100% = $11.00
2600	**SURGERY CONSULTATIONS** (Professional attendance at consulting rooms) **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Fee:** $21.00 **Benefit:** 100% = $21.00
2603	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 100% = $38.00
2606	**PROLONGED CONSULTATION** of more than 45 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Fee:** $61.00 **Benefit:** 100% = $61.00
2610	**OUT-OF-SURGERY CONSULTATIONS** (Professional attendance at a place other than consulting rooms) **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient
2613	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient

PROLONGED CONSULTATION of more than 45 minutes duration

AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999.
(See para A.28 of explanatory notes to this Category)
Derived Fee: An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients.
2616 For seven or more patients - an amount equal to $57.50 plus $0.70 per patient

SUBGROUP 2 - COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH DIABETES MELLITUS

The minimum requirements of care needed to be assessed to complete an annual cycle of care for patients with diabetes mellitus are:

-	Assess diabetes control by measuring HbA_{1c}	At least once every year
-	Ensure that a comprehensive eye examination is carried out:	At least once every two years
-	Measure weight and height and calculate BMI*:	At least twice every cycle of care
-	Measure blood pressure:	At least twice every cycle of care
-	Examine feet:	At least twice every cycle of care
-	Measure total cholesterol, triglycerides and HDL cholesterol:	At least once every year
-	Test for microalbuminuria:	At least once every year
-	Provide self-care education:	Patient education regarding diabetes management
-	Review diet:	Reinforce information about appropriate dietary choices
-	Review levels of physical activity:	Reinforce information about appropriate levels of physical activity
-	Check smoking status:	Encourage cessation of smoking (if relevant)
-	Review of medication:	Medication review

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

SURGERY CONSULTATIONS

(Professional attendance at consulting rooms)

STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration

AND which completes the requirements for a full year of care of a patient with established diabetes mellitus.
I *(See para A.29 of explanatory notes to this Category)*
2620 **Fee:** $21.00 **Benefit:** 100% = $21.00

LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration

AND which completes the requirements for a full year of care of a patient with established diabetes mellitus
(See para A.29 of explanatory notes to this Category)
2622 **Fee:** $38.00 **Benefit:** 100% = $38.00

PROLONGED CONSULTATION of more than 45 minutes duration

AND which completes the requirements for a full year of care of a patient with established diabetes mellitus
(See para A.29 of explanatory notes to this Category)
2624 **Fee:** $61.00 **Benefit:** 100% = $61.00

OUT-OF-SURGERY CONSULTATIONS

(Professional attendance at a place other than the consulting rooms)

STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration

AND which completes the requirements for a full year of care of a patient with established diabetes mellitus
(See para A.29 of explanatory notes to this Category)
Derived Fee: An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients.
2631 For seven or more patients - an amount equal to $16.00 plus $0.70 per patient

INCENTIVE ITEMS	OTHER NON-REFFERED
2633	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the requirements for a full year of care of a patient with established diabetes mellitus *(See para A.29 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient
2635	**PROLONGED CONSULTATION** of more than 45 minutes duration AND which completes the requirements for a full year of care of a patient with established diabetes mellitus *(See para A.29 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient
	SUBGROUP 3 - COMPLETION OF THE ASTHMA 3+ VISIT PLAN
2664	**Note: Benefits are payable for only one service included in Subgroup 3 or A18, Subgroup 3 in a 12-month period, unless a further Asthma 3+ Visit Plan is clinically indicated.** At a minimum the Asthma 3+ Visit Plan must include: - documented diagnosis and assessment of severity - at least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with **moderate to severe** asthma - review of the patient's use of asthma related medication - planned recalls for at least two of these consultations - provision of a written asthma action plan and self-management education to the patient, (if the patient is unable to use a written action plan, alternative patient education may be provided and documented in the medical record) - review of asthma action plan **SURGERY CONSULTATIONS** (Professional attendance at consulting rooms) **STANDARD CONSULTATIONS** of more than 5 minutes duration but not more than 25 minutes duration AND which completes the minimum requirements of the Asthma 3+ Visit Plan. *(See para A.30 of explanatory notes to this Category)* **Fee:** $21.00 **Benefit:** 100% = $21.00
2666	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the minimum requirements of the Asthma 3+ Visit Plan. *(See para A.30 of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 100% = $38.00
2668	**PROLONGED CONSULTATION** of more than 45 minutes duration AND which completes the minimum requirements of the Asthma 3+ Visit Plan. *(See para A.30 of explanatory notes to this Category)* **Fee:** $61.00 **Benefit:** 100% = $61.00
2673	**OUT-OF-SURGERY CONSULTATIONS** (Professional attendance at a place other than the consulting rooms) **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration AND which completes the minimum requirements of the Asthma 3+ Visit Plan. *(See para A.30 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient.

2675	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the minimum requirements of the Asthma 3+ Visit Plan. *(See para A.30 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient
2677	**PROLONGED CONSULTATION** of more than 45 minutes duration AND which completes the minimum requirements of the Asthma 3+ Visit Plan. *(See para A.30 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient
	SUBGROUP 4 - COMPLETION OF THE 3 STEP MENTAL HEALTH PROCESS
I 2704	**Note: Benefits included in Subgroup 4, A18 or A19, are payable for one service per patient only in a 12-month period, unless a further 3 Step Mental Health Process is clinically indicated.** At a minimum the 3 Step Mental Health Process must include: - at least 2 consultations of more than twenty minutes each for a patient with an assessed mental health disorder; - at least one of the consultations to have been a planned visit which must include the review step; - an assessment and formulation or diagnosis of the mental health disorder/s; - provision of a written mental health plan and appropriate education to the patient and/or the carer (with the patient's agreement); - a review of the patient's progress against the goals included in the mental health plan. This review to have been conducted a minimum of 4 weeks and a maximum of 6 months from the consultation in which the mental health plan was prepared; and - utilising an outcome tool in the assessment and review stages except where considered clinically inappropriate. The 3 Step Mental Health Process can only be provided by a medical practitioner (not including a general practitioner, a specialist or consultant physician), who practices in general practice and has been notified to Medicare Australia as having the required credentials. **SURGERY CONSULTATIONS** (Professional attendance at consulting rooms) **LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the requirements of the 3 Step Mental Health Process. *(See para A.31 of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 100% = $38.00
2705	**PROLONGED CONSULTATION** of more than 45 minutes duration AND which completes the requirements of the 3 Step Mental Health Process. *(See para A.31 of explanatory notes to this Category)* **Fee:** $61.00 **Benefit:** 100% = $61.00
2707	**OUT-OF-SURGERY CONSULTATIONS** (Professional attendance at a place other than the consulting rooms) **LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the requirements of the 3 Step Mental Health Process. *(See para A.31 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient.

INCENTIVE ITEMS		OTHER NON-REFERRED
2708	**PROLONGED CONSULTATION** of more than 45 minutes duration AND which completes the requirements of the 3 Step Mental Health Process. *(See para A.31 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient.	

GROUP A20 - FOCUSSED PSYCHOLOGICAL STRATEGIES

MEDICAL PRACTITIONER ATTENDANCE (INCLUDING A GENERAL PRACTITIONER, BUT NOT INCLUDING A SPECIALIST OR CONSULTANT PHYSICIAN) ASSOCIATED WITH PROVISION OF FOCUSSED PSYCHOLOGICAL STRATEGIES

Note: These services may only be provided by a medical practitioner who is registered with Medicare Australia as meeting the requirements to participate in the Better Outcomes in Mental Health Care Initiative. The medical practitioner must provide the service in a general practice participating in the PIP or which is accredited.

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies, that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These strategies are required to be provided to patients by a credentialled medical practitioner and are time limited; being deliverable, in general, in up to 6 planned sessions. In some instances, following review by the practitioner managing the 3 Step Mental Health Process, up to a further 6 sessions may be approved in any 12 month period to an individual patient. Medical practitioners must be notified to Medicare Australia by the General Practice Mental Health Standards Collaboration that they have met the required standards for higher level mental health skills.
A session should last for a minimum of 30 minutes.

FPS ATTENDANCE

Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental health disorders by a medical practitioner registered with Medicare Australia as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes to less than 40 minutes.

SURGERY CONSULTATION
(Professional attendance at consulting rooms)
(See para A.32 of explanatory notes to this Category)

2721 **Fee:** $75.25 **Benefit:** 100% = $75.25

OUT-OF-SURGERY CONSULTATION
(Professional attendance at a place other than consulting rooms)
(See para A.32 of explanatory notes to this Category)

2723 **Derived Fee:** The fee for item 2721, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2721 plus $1.60 per patient.

FPS EXTENDED ATTENDANCE

Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental health disorders, by a medical practitioner registered with Medicare Australia as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes.

SURGERY CONSULTATION
(Professional attendance at consulting rooms)
(See para A.32 of explanatory notes to this Category)

2725 **Fee:** $107.70 **Benefit:** 100% = $107.70

OUT-OF-SURGERY CONSULTATION
(Professional attendance at a place other than consulting rooms)
(See para A.32 of explanatory notes to this Category)

2727 **Derived Fee:** The fee for item 2725, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2725 plus $1.60 per patient.

	GROUP A22 - GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	LEVEL 'A' Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management **SURGERY CONSULTATION** Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.5 of explanatory notes to this Category)*
5000	**Fee:** $24.60 **Benefit:** 100% = $24.60
	HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For
5003	seven or more patients - the fee for item 5000 plus $1.60 per patient
	CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For
5007	seven or more patients - the fee for item 5000 plus $1.60 per patient
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For
5010	seven or more patients - the fee for item 5000 plus $1.60 per patient
	LEVEL 'B' Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 5040, 5043, 5046, 5049, 5060, 5063, 5064 or 5067 applies **SURGERY CONSULTATION** (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)*
5020	**Fee:** $41.65 **Benefit:** 100% = $41.65
	HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For
5023	seven or more patients - the fee for item 5020 plus $1.60 per patient
	CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For
5026	seven or more patients - the fee for item 5020 plus $1.60 per patient

5028	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $1.60 per patient
5040	**LEVEL 'C'** Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 5060, 5063, 5064 or 5067 applies. **SURGERY CONSULTATION** (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Fee:** $69.90 **Benefit:** 100% = $69.90
5043	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution). The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $1.60 per patient
5046	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $1.60 per patient
5049	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $1.60 per patient
5060	**LEVEL 'D'** Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan **SURGERY CONSULTATION** (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Fee:** $98.10 **Benefit:** 100% = $98.10
5063	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $1.60 per patient

GENERAL PRACTITIONER	GENERAL PRACTITIONER
5064	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $1.60 per patient
5067	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $1.60 per patient

	GROUP A23 - OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
5200	(Professional attendance at consulting rooms) **BRIEF CONSULTATION** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) **Fee:** $21.00 **Benefit:** 100% = $21.00
5203	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $31.00 **Benefit:** 100% = $31.00
5207	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $48.00 **Benefit:** 100% = $48.00
5208	**PROLONGED CONSULTATION** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $71.00 **Benefit:** 100% = $71.00
5220	**HOME VISITS** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) **BRIEF HOME VISIT** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Derived Fee:** An amount equal to $18.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $.70 per patient
5223	**STANDARD HOME VISIT** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Derived Fee:** An amount equal to $26.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $.70 per patient
5227	**LONG HOME VISIT** of more than 25 minutes duration but not more than 45 minutes duration The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Derived Fee:** An amount equal to $45.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $.70 per patient
5228	**PROLONGED HOME VISIT** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Derived Fee:** An amount equal to $67.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $.70 per patient
5240	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient **BRIEF CONSULTATION** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $18.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $.70 per patient
5243	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $26.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $.70 per patient

5247	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $45.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $.70 per patient
5248	**PROLONGED CONSULTATION** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $67.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $.70 per patient
5260	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) - each patient **BRIEF CONSULTATION** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $18.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $.70 per patient
5263	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $26.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $.70 per patient
5265	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $45.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $.70 per patient
5267	**PROLONGED CONSULTATION** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $67.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $.70 per patient

	GROUP A9 - CONTACT LENSES - ATTENDANCES
	CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS *Note: Benefits may not be claimed under Item 10809 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons* ATTENDANCE FOR THE INVESTIGATION and EVALUATION of a patient for the fitting of CONTACT LENSES, with keratometry and testing with trial lenses and the issue of a prescription - 1 SERVICE IN ANY PERIOD OF 36 CONSECUTIVE MONTHS - patients with ***myopia of 5.0 dioptres or greater*** (spherical equivalent) in 1 eye *(See para A.19 of explanatory notes to this Category)*
10801	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55
	- patients with ***manifest hyperopia of 5.0 dioptres or greater*** (spherical equivalent) in 1 eye *(See para A.19 of explanatory notes to this Category)*
10802	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55
	- patients with ***astigmatism of 3.0 dioptres or greater*** in 1 eye *(See para A.19 of explanatory notes to this Category)*
10803	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55
	- patients with ***irregular astigmatism*** in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens *(See para A.19 of explanatory notes to this Category)*
10804	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55
	- patients with ***anisometropia of 3.0 dioptres or greater*** (difference between spherical equivalents) *(See para A.19 of explanatory notes to this Category)*
10805	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55
	- patients with ***corrected visual acuity of 0.7 logMAR (6/30) or worse*** in both eyes, being patients for whom a contact lens is prescribed as part of a ***telescopic system*** *(See para A.19 of explanatory notes to this Category)*
10806	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55
	- patients for whom a wholly or segmentally ***opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia*** caused by: (i) pathological mydriasis; or (ii) aniridia; or (iii) coloboma of the iris; or (iv) pupillary malformation or distortion; or (v) significant ocular deformity or corneal opacity whether congenital, traumatic or surgical in origin *(See para A.19 of explanatory notes to this Category)*
10807	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55
	- patients who, by reason of physical deformity, are ***unable to wear spectacles*** *(See para A.19 of explanatory notes to this Category)*
10808	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55
	- patients who have a ***medical or optical condition*** (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, where the ***condition is specified*** on the patient's account *(See para A.19 of explanatory notes to this Category)*
10809	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55
	ATTENDANCE FOR THE REFITTING OF CONTACT LENSES with keratometry and testing with trial lenses and the issue of a prescription, where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response **within 36 months of the fitting of a contact lens to which Items 10801 to 10809 apply** *(See para A.20 of explanatory notes to this Category)*
10816	**Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55

SERVICES PROVIDED BY NURSES, ALLIED AND DENTAL HEALTH PROFESSIONALS

CATEGORY 8 – MISCELLANEOUS SERVICES

EXPLANATORY NOTES

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CATEGORY 8 – MISCELLANEOUS SERVICES INCLUDING ALLIED HEALTH AND DENTAL SERVICES

EXPLANATORY NOTES

M.1 Additional bulk billing payment for general medical services (item 10990 and item 10991)

M.1.1 Item 10990 can only be claimed where all of the conditions set out in paragraphs (a) to (d) of item 10990 have been met.

M.1.2 Item 10991 can only be claimed where all of the conditions set out in paragraphs (a) to (e) of item 10991 have been met.

- Item 10991 can only be used where the service is provided at, or from, a practice location that is listed in item 10991. This includes all regional, rural and remote areas (RRMA 3 to 7 under the Rural Remote Metropolitan Areas classification system), all of Tasmania and those areas covered by a Statistical Subdivision (SSD) or Statistical Local Areas (SLA) listed in item 10991 (SSDs and SLAs are specified in the Australian Standard Geographical Classification (ASGC) 2002). If you are not sure whether your practice location is in an eligible area, you can call the HIC on 132 150.
- Practice location is the place associated with the medical practitioner's provider number from which the service has been provided. This includes services performed either at the medical practitioner's surgery, or those services performed away from the surgery using the provider number for that surgery (eg home visits or visits to aged care facilities).
- Where a medical practitioner has a practice location in both an eligible and ineligible area, item 10991 can only be claimed in respect of those services provided at, or from, the eligible practice location.

M.1.3 Item 10990 and item 10991 can only be used in conjunction with items in the General Medical Services Table of the MBS. There are similar items to be used in conjunction with diagnostic imaging services (item 64990 or 64991) or pathology services (item 74990 or 74991).

M.1.4 Item 10990 or item 10991 can be claimed for each item of service claimable under the MBS (other than diagnostic imaging services and pathology services), provided the conditions of the relevant item, 10990 or 10991, are satisfied. For example, item 10990 or 10991 can be claimed in conjunction with attendance items, procedural items (other than diagnostic imaging or pathology items) or services provided by a practice nurse on behalf of a medical practitioner (items 10993, 10996, 10998 and 10999). In some cases, this will mean that item 10990 or 10991 can be claimed more than once in respect of a patient visit.

M.1.5 Item 10990 or 10991 can not be claimed in conjunction with each other.

M.1.6 Where a Medicare benefit is not payable for a particular service (eg because the patient has exceeded the number of allowable services in a period of time), the additional bulk billing payment will not be paid for that service.

M.1.7 All GPs whether vocationally registered or not are eligible to claim the additional bulk billing payment.

M.1.8 Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

M.1.9 Unreferred service means a medical service provided to a patient by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.

M.1.10 HIC will undertake regular post payment auditing to ensure that the additional bulk billing payment is being claimed correctly. Centrelink data will be used to verify concessional status and Medicare records will be used to confirm patient age.

After-hours services provided in areas eligible for the higher bulk billing payment (item 10992)

M1.11 Item 10992 can only be claimed where all of the conditions set out in paragraphs (a) to (g) of item 10992 have been met:

- Item 10992 must be claimed in conjunction with one of the items listed in item 10992. These items are for services provided after-hours outside of consulting rooms or hospital.
- Item 10992 can only be used where the service is provided in one of the eligible areas listed in item 10992 by a medical practitioner whose practice location (ie the location associated with the medical practitioner's provider number) is not in one of these areas.
- Medical practitioners whose practice location is inside one of these listed locations should claim item 10991 for eligible services.

M1.12 Item 10992 cannot be claimed in conjunction with item 10990 or 10991.

M1.13 Where a Medicare benefit is not payable for a particular service the payment for item 10992 will not be paid for that service.

M1.14 All GPs, whether vocationally registered or not, are eligible to claim the additional bulk billing payment.

M1.15 Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or

White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.
M1.16 Unreferred service means a medical service provided to a patient by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.
M1.17 HIC will undertake regular post payment auditing to ensure that the additional bulk billing payment is being claimed correctly. Centrelink data will be used to verify concessional status and Medicare records will be used to confirm patient age.

M.2 Services provided by a practice nurse on behalf of a medical practitioner

Immunisation services provided by a practice nurse (item 10993)

M.2.1 Item 10993 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where an immunisation is provided to a patient by a practice nurse on behalf of the medical practitioner.
M.2.2 Item 10993 can be claimed only once per patient visit, even if more than one vaccine is administered during the same patient visit.
M.2.3 A practice nurse means a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. The practice nurse must be appropriately qualified and trained to provide immunisations. This includes compliance with any state or territory requirements. For example, in some states and territories, some nurses can only administer a vaccine following an order or direction from a medical practitioner.
M.2.4 The medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the patient.
M.2.5 Immunisation means the administration of a registered vaccine to a patient for any purpose other than as part of a mass immunisation of persons.
M.2.6 A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods. This includes all vaccines on the Australian Standard Vaccination Schedule and vaccines covered in the Australian Immunisation Handbook 8th edition. The following substances cannot be claimed under this item: vaccines used experimentally; homeopathic substances; immunotherapy for allergies (eg de-sensitisation preparations); and other substances that are not vaccines. There may also be state or territory limitations on the administration of some vaccines, such as those for tuberculosis, yellow fever and Q-fever.
M.2.7 All GPs whether vocationally registered or not are eligible to claim this item.
M.2.8 Where the medical practitioner also provides a service to the patient prior to the immunisation being administered by the practice nurse, the medical practitioner will still be able to claim for the professional service they provide to the patient.
M2.9 Item 10990 or item 10991 can also be claimed in conjunction with item 10993 provided the conditions of the relevant item, 10990 or 10991, are satisfied (see explanatory note M.1).

Wound management services provided by a practice nurse (item 10996)

M.2.10 Item 10996 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where wound management (other than normal aftercare) is provided to a patient by a practice nurse on behalf of the medical practitioner.
M.2.11 Item 10996 can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.
M.2.12 A practice nurse means a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice.
M.2.13 The practice nurse must be appropriately qualified and trained to treat wounds.
M.2.14 The medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient.
M.2.15 The medical practitioner does not need to be present during the treatment of the wound. However, the medical practitioner must conduct an initial assessment of the patient in order to give instruction in relation to the treatment of the wound.
M.2.16 Where a practice nurse provides ongoing wound management, the medical practitioner is not required to see the patient during each subsequent visit.
M.2.17 All GPs whether vocationally registered or not are eligible to claim this item.
M.2.18 Where the medical practitioner also provides a service to the patient prior to the treatment by the practice nurse, the medical practitioner will still be able to claim for the professional service they provide to the patient.
M.2.19 Item 10990 or item 10991 can also be claimed in conjunction with item 10996 provided the conditions of the relevant item, 10990 or 10991, are satisfied (see explanatory note M.1).

Pap smear services provided by a practice nurse (item 10998 and 10999)

M.2.20 Item 10998 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where a Pap smear is taken by a practice nurse on behalf of the medical practitioner at a practice location in a regional, rural or remote area.
M.2.21 Item 10999 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where a Pap smear is taken by a practice nurse on behalf of the medical practitioner at a practice location in a regional, rural or remote area **and** the Pap smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a Pap smear in the last 4 years.

M.2.22 Where the medical practitioner claims item 10999 instead of a Practice Incentives Program (PIP) item (2497 – 2509 and 2598 – 2616) for an unscreened or significantly underscreened woman, a PIP cervical screening incentive will still be available. This incentive will be paid to the medical practitioner claiming item 10999 if the service was provided in a general practice participating in the PIP. A further PIP incentive is paid to practices that reach target levels of cervical screening for their female patients aged 20-69. More detailed information on these incentives is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip

M.2.23 Item 10999 can not be claimed in conjunction with items 10998, 2497 – 2509 and 2598 – 2616.

M.2.24 A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

M.2.25 A practice location is the place associated with the medical practitioner's provider number from which the service has been provided. If you are unsure if your practice location is in an eligible area you can call the HIC on 132 150.

M.2.26 A practice nurse means a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice.

M.2.27 The practice nurse must be appropriately qualified and trained to take cervical smears. This means that where credentialling arrangements are in place, the practice nurse should be credentialled as qualified and trained to take Pap smears. All practice nurses taking Pap smears should have undertaken an accredited training course.

M.2.28 Continuing professional development is a compulsory part of the credentialling arrangements and is recommended for all nurses taking Pap smears in jurisdictions where there are currently no credentialling arrangements.

M.2.29 General practices, where nurses take Pap smears, should also have a written clinical risk management strategy covering issues like clinical roles, pathology follow-up and patient consent.

M.2.30 The practice nurse must also comply with any relevant legislative or regulatory requirements, including those applying to state and territory cervical cytology registers or laboratories.

M.2.31 In all cases, the medical practitioner under whose supervision the Pap smear is taken retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the practice nurse is appropriately qualified and trained to take Pap smears.

M.2.32 The medical practitioner is not required to see the patient first or to be present while the Pap smear is taken. It is up to the medical practitioner to decide whether they need to initially see the patient. Where a consultation has taken place with the patient first then the medical practitioner is entitled to claim for that professional service.

M.2.33 All GPs whether vocationally registered or not are eligible to claim this item.

M.2.34 Item 10991 can also be claimed in conjunction with item 10998 and 10999 provided the conditions of item 10991 are satisfied (see explanatory note M.1)

GROUP M3 - ALLIED HEALTH SERVICES

I 10950	Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible Aboriginal health worker by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible Aboriginal health worker gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period **Fee: $**3.90 **Benefit:** 85% **$**85.85
I 10951	Diabetes education health service provided to a person by an eligible diabetes educator if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible diabetes educator by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period **Fee: $**3.90 **Benefit:** 85% **$**85.85

	Audiology health service provided to a person by an eligible audiologist if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible audiologist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible audiologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period
I 10952	**Fee: $**2.85 **Benefit:** 85%=$4.95
	Dietetics health service provided to a person by an eligible dietitian if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible dietitian by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period
I 10954	**Fee: $**3.90 **Benefit:** 85%=$5.85
	Mental health service provided to a person by an eligible mental health worker if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible mental health worker by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period
I 10956	**Fee: $**3.90 **Benefit:** 85%=$5.85

I 10958	Occupational therapy health service provided to a person by an eligible occupational therapist if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible occupational therapist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible occupational therapist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period **Fee: $**3.90 **Benefit:** 85% = $5.85
I 10960	Physiotherapy health service provided to a person by an eligible physiotherapist if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible physiotherapist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period **Fee: $**3.90 **Benefit:** 85% = $5.85

	Chiropody health service provided to a person by an eligible chiropodist, or podiatry health service provided to a person by an eligible podiatrist if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible chiropidist or eligible podiatrist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible chiropodist or eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit;
I 10962	- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period **Fee: $**3.90 **Benefit:** 85% = $5.85
	Chiropractic health service provided to a person by an eligible chiropractor if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible chiropractor by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit;
I 10964	- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period **Fee: $**3.90 **Benefit:** 85% = $5.85
	Osteopathy health service provided to a person by an eligible osteopath if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible osteopath by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit;
I 10966	- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period **Fee: $**3.90 **Benefit:** 85% = $5.85

I 10968	Psychology health service provided to a person by an eligible psychologist if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible psychologist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible psychologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period **Fee: $**3.90 **Benefit:** 85% **$**5.85
I 10970	Speech pathology health service provided to a person by an eligible speech pathologist if: (a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible speech pathologist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible speech pathologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 month period **Fee: $**3.90 **Benefit:** 85% **$**5.85

	GROUP M4 - DENTAL SERVICES
I 10975	Dental assessment provided to a person by an eligible dental practitioner if: (a) the service is provided to a person whose dental condition is exacerbating a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible dental practitioner by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) after the assessment, the eligible dental practitioner gives a written report to the referring medical practitioner; and (f) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 3 services (including any services to which this item or item 10976 or 10977 applies) in a 12 month period **Fee:** $89.80 **Benefit:** 85% $76.35
I 10976	Dental treatment provided to a person by an eligible dental practitioner if: (a) the service is provided to a person whose dental condition is exacerbating a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the service is associated with a service of the kind described in item 10975 previously provided to the person; and (d) the person is referred to the eligible dental practitioner by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (e) the person is not an admitted patient of a hospital or day-hospital facility; and (f) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 3 services (including any services to which this item or item 10975 or 10977 applies) in a 12 month period **Fee:** $89.80 **Benefit:** 85% $76.35
I 10977	Dental service provided to a person by an eligible dental practitioner or an eligible dental specialist (the ***providing dentist***) if: (a) the service is provided to a person whose dental condition is exacerbating a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the service is associated with a service of the kind described in item 10975 previously provided to the person by another eligible dental practitioner; and (d) the person is referred to the providing dentist by the eligible dental practitioner who provided the service described in item 10975 using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substanially complies with the form issued by the Department; and (e) the person is not an admitted patient of a hospital or day-hospital facility; and (f) after the service, the providing dentist gives a written report to the referring eligible dental practitioner and the medical practitioner mentioned in paragraph (a); and (g) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 3 services (including any services to which this item or item 10975 or 10976 applies) in a 12 month period **Fee:** $89.80 **Benefit:** 85% $76.35

GROUP M1 - MANAGEMENT OF BULK-BILLED SERVICES

	A medical service to which an item in this table (other than this item or item 10991) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital or day-hospital facility; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service *(See para M1 of explanatory notes to this Category)*
10990	**Fee:** $5.05 **Benefit:** 85% $5.15
	A medical service to which an item in this table (other than this item or item 10990) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital or day-hospital facility; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service: and (e) the service is provided at, or from, a practice location in: (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) A geographical area included in any of the following SSD spatial units: (A) Beaudesert Shire Part A (B) Belconnen (C) Darwin City (D) Eastern Outer Melbourne (E) East Metropolitan (F) Frankston City (G) Gosford-Wyong (H) Greater Geelong City Part A (I) Gungahlin-Hall (J) Ipswich City (part in BSD) (K) Litchfield Shire (L) Melton-Wyndham (M) Mornington Peninsula Shire (N) Newcastle (O) North Canberra (P) Palmerston-East Arm (Q) Pine Rivers Shire (R) Queanbeyan (S) South Canberra (T) South Eastern Outer Melbourne (U) Southern Adelaide (V) South West Metropolitan (W) Thuringowa City Part A (X) Townsville City Part A (Y) Tuggeranong (Z) Weston Creek-Stromlo (ZA) Woden Valley (ZB) Yarra Ranges Shire Part A; or (iv) the geographical area included in the SLA spatial unit of Palm Island (AC) *(See para M1 of explanatory notes to this Category)*
10991	**Fee:** $9.20 **Benefit:** 85% $8.85

A medical service to which item 1, 97, 601, 697, 5003, 5007, 5010, 5023, 5026, 5028, 5043, 5046, 5049, 5063, 5064, 5067, 5220, 5223, 5227, 5228, 5240, 5243, 5247, 5248, 5260, 5263, 5265 or 5267 applies if:

(a) the service is an unreferred service; and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital or approved day-hospital facility; and

(d) the service is not provided in consulting rooms; and

(e) the service is provided in one of the following eligible areas:

(i) a regional, rural or remote area; or

(ii) Tasmania; or

(iii) A geographical area included in any of the following SSD spatial units:

(A) Beaudesert Shire Part A
(B) Belconnen
(C) Darwin City
(D) Eastern Outer Melbourne
(E) East Metropolitan, Perth
(F) Frankston City
(G) Gosford-Wyong
(H) Greater Geelong City Part A
(I) Gungahlin-Hall
(J) Ipswich City (part in BSD)
(K) Litchfield Shire
(L) Melton-Wyndham
(M) Mornington Peninsula Shire
(N) Newcastle
(O) North Canberra
(P) Palmerston-East Arm
(Q) Pine Rivers Shire
(R) Queanbeyan
(S) South Canberra
(T) South Eastern Outer Melbourne
(U) Southern Adelaide
(V) South West Metropolitan, Perth
(W) Thuringowa City Part A
(X) Townsville City Part A
(Y) Tuggeranong
(Z) Weston Creek-Stromlo
(ZA) Woden Valley
(ZB) Yarra Ranges Shire Part A; or

(iv) the geographical area included in the SLA spatial unit of Palm Island (AC)

(f) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an eligible area; and

(g) the service is bulk billed in respect of the fees for:

(i) this item; and

(ii) the other item in this table applying to the service.

(See para M1 of explanatory notes to this Category)

10992 **Fee:** $9.20 **Benefit:** 85% $8.85

	GROUP M2 - SERVICES PROVIDED BY A PRACTICE NURSE ON BEHALF OF A MEDICAL PRACTITIONER
10993	Immunisation provided to a person by a practice nurse: if (a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner: and (b) the immunisation is provided: (i) in the consulting rooms of a general practice; or (ii) in a residential aged facility: or (iii) during a home visit to the person: or (iv) in an institution (other than a hospital or day-hospital facility) *(See para M2 of explanatory notes to this Category)* **Fee:** $0.40 **Benefit:** 100% $0.40
10996	Treatment of a person's wound (other than normal aftercare) provided by a practice nurse if: (a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner: and (b) the person is not an admitted patient of a hospital or day-hospital facility *(See para M2 of explanatory notes to this Category)* **Fee:** $0.40 **Benefit:** 100% $0.40
10998	Service provided by a practice nurse, being the taking of a cervical smear from a person, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the person is not an admitted patient of a hospital or approved day hospital facility. *(See para M2 of explanatory notes to this Category)* **Fee:** $0.40 **Benefit:** 100% $0.40
10999	Service provided by a practice nurse, being the taking of a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the person is not an admitted patient of a hospital or approved day hospital facility. this item cannot be claimed with items 2497-2509 and 2598-2616 (See para M2 of explanatory notes to this Category) Fee: $0.40 Benefit: 100% $0.40

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

CATEGORY 2

CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

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CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

EXPLANATORY NOTES

MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

D1.1 Electronencephalography (EEG), Prolonged Recording (item 11003)

D1.1.1 Extended EEG recording of at least 3 hours duration, other than ambulatory or video recording, including Multiple Sleep Latency Testing (MSLT) is covered under item 11003.

D1.2 Electronencephalography (EEG), Ambulatory or Video, Prolonged Recording (items 11004 and 11005)

D1.2.1 These items cover prolonged ambulatory or video EEG, recording of at least 3 hours duration for:

- Diagnosing the basis of episodic neurological dysfunction;
- Characterising the nature of a patient's epileptic seizures;
- Localising seizures in patients with uncontrolled epilepsy, with a view to surgery; or
- Assessing treatment response where subclinical seizures are suspected.

D1.2.2 For extended ambulatory or video EEG of at least 3 hours but not more than 24 hours duration, item 11004 should be claimed. However, where ambulatory or video EEEG extends over several days, item 11004 covers recording on the first day and item 11005 for every day subsequent to the first.

D1.2.3 Extended EEG recording of at least 3 hours duration, other than ambulatory or video recording, including Multiple Sleep Latency Testing (MSLT) is covered under item 11003.

D1.3 Neuromuscular Diagnosis (Item 11012)

D1.3.1 Based on advice from the Australian Association of Neurologists, Medicare benefits are not payable under Item 11012 for quantitative sensory nerve testing using "Neurometer CPT" diagnostic devices. The advice indicated that the device was still in the evaluation and research stage and did not have widespread clinical application.

D1.4 Investigation of Central Nervous System Evoked Responses (Items 11024 and 11027)

D1.4.1 In the context of these items a study refers to one or more averaged samples of electrical activity recorded from one or more sites in the central nervous system in response to the same stimulus.

D1.4.2 Second or subsequent studies refer to either stimulating the point of stimulation (e.g. right eye or left median nerve) with a different stimulus or stimulating another point of stimulation (e.g. left eye or right median nerve).

D1.4.3 Items 11024 and 11027 are not intended to cover bio-feedback techniques.

D1.5 Electroretinography (Items 11204, 11205, 11210, 11211)

D1.5.1 Current professional guidelines and standards for electroretinography, electroculography and pattern retinography are produced by the International Society for Clinical Electrophysiology of Vision (ISCEV).

D1.6 Computerised Perimetry Printed Results (Items 11221 – 11225)

D1.6.1 New items have been introduced into the Schedule from 1 November 2003 for computerised perimetry by optometrists (Optometry Schedule items 10940 and 10941). Where such perimetry has been performed and the optometrist is referring the patient to an ophthalmologist for further treatment, and where the results of the perimetry have been provided, items 11221 – 11225 should not be used to repeat perimetry unless clinically necessary.

D1.7 Computerised Perimetry (Items 11222 and 11225)

D1.7.1 Item 11222 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 11225 for unilateral procedures should be claimed, where appropriate.

D1.7.2 These items relate to computerised perimetry (bilateral or unilateral) where a third or subsequent examination becomes necessary in a 12 month period. As indicated in the descriptions, these items apply only where a further examination is indicated in the presence of one of the following conditions:-

- established glaucoma where surgery may be required within a 6 month period and where there has been definite progression of damage over a 12 month period;
- established neurological disease which may be progressive and where a visual field is necessary for the management of the patient; or
- monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, where there may also be disease such as glaucoma or neurological disease.

D1.7.3 Claims for benefits in respect of Items 11222 and 11225 should be accompanied by clinical details confirming the presence of one of the above conditions. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

D1.8 Multifocal Multichannel Objective Perimetry (Items 11024, 11027, 11221, 11222, 11224 and 11225)

D1.8.1 Following an MSAC assessment of Multifocal Multichannel Objective Perimetry (MMOP), it was recommended that public funding not be supported for MMOP at this time therefore medical benefits are not payable for any MMOP procedures.

D1.8.2 A restriction has been placed on the items 11024, 11027, 11221, 11222, 11224 and 11225 to exclude the use of MMOP and those items should not be claimed for MMOP.

D1.9 Orbital Contents (Items 11240, 11241, 11242, 11243)

D1.9.1 Where an additional service is necessary items 11242 and 11243 should be utilised.

D1.9.2 Partial coherence interferometry may also be referred to as optical (or ocular) coherence biometry/tomography or laser Doppler interferometry.

D1.10 Brain Stem Evoked Response Audiometry (Item 11300)

D1.10.1 Item 11300 can be claimed for the programming of a cochlear speech processor.

D1.11 Electrocochleography (Item 11304)

D1.11.1 This item refers to electrocochleography with insertion of electrodes through the tympanic membrane.

D1.12 Non-determinate Audiometry (Item 11306)

D1.12.1 This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11321 when not performed under the conditions set out in paragraph D1.12.1.

D1.13 Audiology Services (Items 11309 - 11321)

D1.13.1 A medical service specified in Items 11309 to 11321 shall be taken to be a medical service for the purposes of payment of benefits if, and only if, it is rendered:

(a) in conditions that allow the establishment of determinate thresholds;

(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS 1269.3.1998 of the Standards Association of Australia, being that Standard as in force or existing on 1 August 1987; and

(c) using calibrated equipment that complies with Australian Standard AS 2586-1983 of the Standards Association of Australia, being that Standard as in force or existing on 1 August 1987.

D1.14 Oto-acoustic Emission Audiometry (Item 11332)

D1.14.1 Medicare benefits are not payable under Item 11332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

D1.15 Respiratory Function Tests (Item 11503)

D1.15.1 The investigations listed hereunder would attract benefits under Item 11503. This list has been prepared in consultation with the Thoracic Society of Australia and New Zealand.

(a) Carbon monoxide diffusing capacity by any method

(b) Absolute lung volumes by any method

(c) Assessment of arterial carbon dioxide tension or cardiac output - re breathing method

(d) Assessment of pulmonary distensibility involving measurement of lung volumes and oesophageal pressure

(e) Measurement of airway or pulmonary resistance by any method

(f) Measurement of respiratory muscle strength involving the measurement of trans-diaphragmatic or oesophageal pressures

(g) Assessment of phrenic nerve function involving percutaneous stimulation and measurement of the compound action potential of the diaphragm

(h) Measurement of the resistance of the anterior nares or pharynx

(i) Inhalation provocation testing, including pre-provocation spirometry, the construction of a dose response curve, using histamine, cholinergic agents or non-istonic fluids and post-bronchodilator spirometry

(j) Exercise testing using incremental workloads with monitoring of ventilatory and cardiac responses at rest, during exercise and recovery on premises equipped with a mechanical ventilator and defibrillator

(k) Tests of distribution of ventilation involving inhalation of inert gases

(l) Measurement of gas exchange involving simultaneous collection of arterial blood and expired air with measurements of the partial pressures of oxygen and carbon dioxide in gas and blood

(m) Multiple inert gas elimination techniques for measuring ventilation perfusion ratios in the lung

(n) Continuous monitoring of pulmonary function other than spirometry, tidal breathing and minute ventilation, of at least 6 hours duration

(o) Ventilatory and/or occlusion pressure responses to progressive hypercapnia and progressive hypoxia

(p) Monitoring pulmonary arterial pressure at rest or during exercise

(q) Measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes

(r) Measurement of the respiratory muscle endurance/fatigability by any technique
(s) Measurement of respiratory muscle strength before and after intravenous injection of placebo and anticholinesterase drugs
(t) Simulated altitude test involving exposure to hypoxic gas mixtures and measurement of ventilation, heart rate and oxygen saturation at rest and/or during exercise and observation of the effect of supplemental oxygen
(u) Inhalation provocation testing to specific sensitising agents
(v) Spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises capable of performing complex lung function tests and equipped with a mechanical ventilator and defibrillator.

D1.16 Investigations of Venous Disease (Items 11602, 11604, 11605)

D1.16.1 These items relate to examinations performed in the investigation of venous disease and result from separating out the services previously claimed under item 11603 to better reflect current practice. The fees include components for interpretation of the results and provision of hard copy trace and report, the report component of which must be performed by a medical practitioner**.** Doppler examinations without hard copy trace cannot be claimed as they are considered to be part of a consultation. Claiming of item 11602 is restricted to twice per patient per year.

D1.16.2 Items 11602, 11604 and 11605 which are diagnostic items, should not be used in conjunction with sclerotherapy (echosclerotherapy).

D1.16.3 In item 11604, photoplethysmography is specifically excluded from the range of plethysmography techniques which may be used in order for this item to be claimed.

D1.16.4 In item 11605, infrared photoplethysmography is to be used, but only in complex cases, in order to assess venous function to determine surgical intervention or the conservative management of deep vein thrombosis.

D1.17 Investigations of Arterial Disease (Items 11610, 11611, 11614)

D1.17.1 These items relate to examinations performed in the investigation of arterial disease and result from separating out the services previously claimed under item 11603 to better reflect current practice. The fees include components for interpretation of the results and provision of hard copy trace or recording of waveforms and report, the report component of which must be performed by a medical practitioner.

D1.18 Twelve-lead Electrocardiography (Item 11700)

D1.18.1 Benefits are precluded under this item unless a full 12-lead ECG is performed. Examinations involving less than twelve leads are regarded as part of the accompanying consultation. A 12-lead ECG refers to the recordings produced of 12 views of the heart by various combinations of placement of electrodes.

D1.19 Twelve-lead Electrocardiography, Report Only (Item 11701)

D1.19.1 This item provides a benefit where tracings are referred to a medical practitioner for a report without an attendance on the patient by that practitioner. Where a patient is referred to a consultant for a consultation and takes ECG tracings with him/her, a separate benefit is not payable for the consultant's interpretation of the tracings.

D1.20 Electrocardiographic (ECG) Recording of Ambulatory Patient (Items 11708, 11709)

D1.20.1 Medicare benefits are not payable for ambulatory blood pressure monitoring (under Item 11708 or 11709 or any other item). Likewise, where blood pressure monitoring and continuous ECG recording are undertaken conjointly on an ambulatory patient for 12 hours or more, benefits are not payable for the blood pressure monitoring or for the continuous ECG recording under Item 11708 or 11709.

D1.20.2 Items 11708 and 11709 require the continuous ECG recording of an ambulatory patient for twelve hours or more. Benefits are only payable under these items if the ECG data is analysed and reported on by a specialist physician or consultant physician.

D1.20.3 The changing of a tape or batteries is regarded as a continuation of the service and does not constitute a separate service for benefit purposes. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode would be regarded as a separate service.

D1.21 Signal Averaged ECG Recording (Item 11713)

D1.21.1 Benefits are only payable under this item if the ECG data is analysed and reported on by a specialist physician or a consultant physician.

D1.22 Capsule Endoscopy to investigate obscure gastrointestinal bleeding (Item 11820)

D1.22.1 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, 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.

D1.22.2 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.

D1.21.3 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 Medicare Australia notified of that recognition.

D1.22.4 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 the GESA

D1.23 Epicutaneous Patch Testing (Items 12012, 12015 & 12018)

D1.23.1 A standard epicutaneous patch test battery refers to the European Standard Series or the International Contact Research Group Standard Series.

D1.24 Administration of thyrotropin alfa-rch for the detection of recurrent well-differentiated thyroid cancer (Item 12201)

D1.24.1 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.

D1.24.2 “Severe psychiatric illness” is defined as patients with a severe pre-existing psychiatric illness who are currently under specialist psychiatric care.

D1.24.3 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 72 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.

D1.24.4 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.

D1.25 Investigations for Sleep Apnoea (Items 12203, 12207, 12210, 12213, 12215 and 12217)

D1.25.1 A “qualified adult sleep medicine practitioner” as described in Items 12203 and 12207, a “qualified paediatric sleep medicine practitioner” as described in Items 12210 and 12213 and a “qualified sleep medicine practitioner” as described in Items 12215 and 12217 means:

For practitioners who commence providing sleep studies before 1 March 1999:

(a) a person who, before 1 March 1999, has been assessed by the Credentialling Subcommittee (the Credentialling Subcommittee) of the Specialist Advisory Committee in Respiratory and Sleep Medicine of the Royal Australasian College of Physicians as having sufficient training and experience in either adult or paediatric sleep medicine to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies; or

(b) a person who, before 1 March 1999, has been assessed by the Credentialling Subcommittee as having substantial training or experience in either adult or paediatric sleep medicine but as requiring further specified training or experience in sleep medicine to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies. This will apply for two years after the assessment; or

(c) a person mentioned in paragraph (b) who has finished the training or gained the experience specified for that person that has been verified by the Credentialling Subcommittee; OR

For practitioners who commence providing sleep studies after 1 March 1999

(d) a person who after completing at least 12 months core training, including clinical practice in sleep medicine and in reporting sleep studies, has attained Level I or Level II of the Advanced Training program in either Adult or Paediatric Sleep Medicine of the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association; or

(e) a person whom the Specialist Advisory Committee in Respiratory and Sleep Medicine of the Royal Australasian College of Physicians has recognised, in writing, as having training equivalent to the training mentioned in paragraph (d) above.

D1.25.2 In relation to paragraph (d) of these items, generally, the patient should be seen in consultation by a qualified sleep medicine practitioner to determine the necessity for the investigation unless the necessity has been clearly established by other means.

D1.25.3 Item 12207 relates to overnight investigation of sleep apnoea where a fourth or subsequent investigation becomes necessary in a twelve month period where all of the following conditions apply:-

- the patient has severe cardio-respiratory failure; and
- previous studies have demonstrated failure of continuous positive airway pressure or oxygen; and
- the study is for the adjustment and/or testing of the effectiveness of a positive pressure ventilatory support device (other than nasal continuous positive airway pressure)

D1.25.4 Items 12215 and 12217 relate to overnight investigation for sleep apnoea where a fourth or subsequent investigation becomes necessary in a twelve month period when therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required.

D1.25.5 Claims for benefits in respect of items 12207, 12215 and 12217 should be accompanied by clinical details confirming the presence of the conditions set out in D1.25.3 and D1.25.4. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked "Medical-in-Confidence". (see note 8.7 of the General Explanatory Notes.)

D1.26 Bone Densitometry (Items 12306 to 12321)

D1.26.1 Item 12321 is intended to allow for bone mineral density measurement following a significant change in therapy - e.g. a change in the class of drugs - rather than for a change in the dosage regimen.

D1.26.2 An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. If technical difficulties preclude measurement at these sites, other sites can be used for the purpose of measurements. The measurement of bone mineral density at both forearms or both heels or in combination is excluded for the purpose of Medicare benefit.

Referrals

D1.26.3 Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of Items 12306, 12309, 12312, 12315, 12318 and 12321.

D1.26.4 For Items 12306 and 12309 the referral should specify the indication for the test, namely:

(a) 1 or more fractures occurring after minimal trauma; or
(b) monitoring of low bone mineral density proven by previous bone densitometry.

D1.26.5 For Item 12312 the referral should specify the indication for the test, namely:

(a) prolonged glucocorticoid therapy;
(b) conditions associated with excess glucocorticoid secretion;
(c) male hypogonadism; or
(d) female hypogonadism lasting more than 6 months before the age of 45.

D1.26.6 For Item 12315 the referral should specify the indication for the test, namely:

(a) primary hyperparathyroidism;
(b) chronic liver disease;
(c) chronic renal disease;
(d) proven malabsorptive disorders;
(e) rheumatoid arthritis; or
(f) conditions associated with thyroxine excess.

D1.26.7 For Item 12318 the referral should specify the indication for the test, namely:

(a) prolonged glucocorticoid therapy;
(b) conditions associated with excess glucocorticoid secretion;
(c) male hypogonadism;
(d) female hypogonadism lasting more than 6 months before the age of 45;
(e) primary hyperparathyroidism;
(f) chronic liver disease;
(g) chronic renal disease;
(h) proven malabsorptive disorders;
(i) rheumatoid arthritis; or
(j) conditions associated with thyroxine excess.

Definitions

D1.26.8 Low bone mineral density is present when the bone (organ) mineral density falls more than 1.5 standard deviations below the age matched mean or more than 2.5 standard deviations below the young normal mean at the same site and in the same gender.

D1.26.9 For Items 12312 and 12318

(a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or
(b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day;
for a period anticipated to last for at least 4 months.
Glucocorticoid therapy must be contemporaneous with the current scan. Patients no longer on steroids would not qualify for benefits.

D1.26.10 For Items 12312 and 12318

(a) Male hypogonadism is defined as serum testosterone levels below the age matched normal range.
(b) Female hypogonadism is defined as serum oestrogen levels below the age matched normal range.

D1.26.11 For Items 12315 and 12318

A malabsorptive disorder is defined as one or more of the following:

(a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or
(b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level; or
(c) histologically proven Coeliac disease.

	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 1 - NEUROLOGY
11000	ELECTROENCEPHALOGRAPHY, not being a service: (a) associated with a service to which item 11003, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.) **Fee:** $106.55 **Benefit:** 75% = $79.95 85% = $90.60
11003	ELECTROENCEPHALOGRAPHY, prolonged recording of at least 3 hours duration, not being a service: (a) associated with a service to which item 11000, 11004, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices *(See para D1.1 of explanatory notes to this Category)* **Fee:** $281.95 **Benefit:** 75% = $211.50 85% = $239.70
11004	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices *(See para D1.2 of explanatory notes to this Category)* **Fee:** $281.95 **Benefit:** 75% = $211.50 85% = $239.70
11005	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on each day subsequent to the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11004, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices *(See para D1.2 of explanatory notes to this Category)* **Fee:** $281.95 **Benefit:** 75% = $211.50 85% = $239.70
11006	ELECTROENCEPHALOGRAPHY, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices **Fee:** $144.55 **Benefit:** 75% = $108.45 85% = $122.90
11009	ELECTROCORTICOGRAPHY **Fee:** $197.05 **Benefit:** 75% = $147.80 85% = $167.50
11012	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies) *(See para D1.3 of explanatory notes to this Category)* **Fee:** $96.85 **Benefit:** 75% = $72.65 85% = $82.35
11015	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies) **Fee:** $129.75 **Benefit:** 75% = $97.35 85% = $110.30
11018	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies) **Fee:** $193.85 **Benefit:** 75% = $145.40 85% = $164.80
11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations **Fee:** $129.75 **Benefit:** 75% = $97.35 85% = $110.30
11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 1 or 2 studies *(See para D1.4 and D1.8 of explanatory notes to this Category)* **Fee:** $98.60 **Benefit:** 75% = $73.95 85% = $83.85
11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 3 or more studies *(See para D1.4 and D1.8 of explanatory notes to this Category)* **Fee:** $146.15 **Benefit:** 75% = $109.65 85% = $124.25

SUBGROUP 2 - OPHTHALMOLOGY

11200	PROVOCATIVE TEST OR TESTS FOR GLAUCOMA, including water drinking **Fee:** $35.30 **Benefit:** 75% = $26.50 85% = $30.05
11203	TONOGRAPHY in the investigation or management of glaucoma, 1 or both eyes using an electrical tonography machine producing a directly recorded tracing **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
11204	ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards *(See para D1.5 of explanatory notes to this Category)* **Fee:** $93.70 **Benefit:** 75% = $70.30 85% = $79.65
11205	ELECTROOCULOGRAPHY of one or both eyes performed according to current professional guidelines or standards *(See para D1.5 of explanatory notes to this Category)* **Fee:** $93.70 **Benefit:** 75% = $70.30 85% = $79.65
11210	PATTERN ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards *(See para D1.5 of explanatory notes to this Category)* **Fee:** $93.70 **Benefit:** 75% = $70.30 85% = $79.65
11211	DARK ADAPTOMETRY of one or both eyes with a quantitative (log cd /m2) estimation of threshold in log lumens at 45 minutes of dark adaptations *(See para D1.5 of explanatory notes to this Category)* **Fee:** $93.70 **Benefit:** 75% = $70.30 85% = $79.65
11212	OPTIC FUNDI, examination of, following intravenous dye injection **Fee:** $60.70 **Benefit:** 75% = $45.55 85% = $51.60
11215	RETINAL PHOTOGRAPHY, multiple exposures of 1 eye with intravenous dye injection **Fee:** $106.45 **Benefit:** 75% = $79.85 85% = $90.50
11218	RETINAL PHOTOGRAPHY, multiple exposures of both eyes with intravenous dye injection **Fee:** $131.50 **Benefit:** 75% = $98.65 85% = $111.80
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:** $58.65 **Benefit:** 75% = $44.00 85% = $49.90
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 and D1.7 and D1.8 of explanatory notes to this Category)* **Fee:** $58.65 **Benefit:** 75% = $44.00 85% = $49.90
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:** $35.35 **Benefit:** 75% = $26.55 85% = $30.05

11225	FULL QANTITATIVE 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 and D1.7 and D1.8 of explanatory notes to this Category)* **Fee:** $35.35	**Benefit:** 75% = $26.55	85% = $30.05
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:** $106.20	**Benefit:** 75% = $79.65	85% = $90.30
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:** $70.45	**Benefit:** 75% = $52.85	85% = $59.90
11240	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, 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:** $70.45	**Benefit:** 75% = $52.85	85% = $59.90
11241	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, 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:** $89.70	**Benefit:** 75% = $67.30	85% = $76.25
11242	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, 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:** $69.35	**Benefit:** 75% = $52.05	85% = $58.95
11243	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, 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:** $69.35	**Benefit:** 75% = $52.05	85% = $58.95
	SUBGROUP 3 - OTOLARYNGOLOGY		
11300	BRAIN stem evoked response audiometry (Anaes.) *(See para D1.10 of explanatory notes to this Category)* **Fee:** $166.55	**Benefit:** 75% = $124.95	85% = $141.60
11303	ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears **Fee:** $166.55	**Benefit:** 75% = $124.95	85% = $141.60
11304	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears *(See para D1.11 of explanatory notes to this Category)* **Fee:** $274.30	**Benefit:** 75% = $205.75	85% = $233.20
11306	Nondeterminate AUDIOMETRY *(See para D1.12 of explanatory notes to this Category)* **Fee:** $19.00	**Benefit:** 75% = $14.25	85% = $16.15
11309	AUDIOGRAM, air conduction *(See para D1.13 of explanatory notes to this Category)* **Fee:** $22.75	**Benefit:** 75% = $17.10	85% = $19.35

11312	AUDIOGRAM, air and bone conduction or air conduction and speech discrimination *(See para D1.13 of explanatory notes to this Category)* **Fee:** $32.15	**Benefit:** 75% = $24.15	85% = $27.35
11315	AUDIOGRAM, air and bone conduction and speech *(See para D1.13 of explanatory notes to this Category)* **Fee:** $42.60	**Benefit:** 75% = $31.95	85% = $36.25
11318	AUDIOGRAM, air and bone conduction and speech, with other Cochlear tests *(See para D1.13 of explanatory notes to this Category)* **Fee:** $52.55	**Benefit:** 75% = $39.45	85% = $44.70
11321	GLYCEROL INDUCED COCHLEAR FUNCTION CHANGES assessed by a minimum of 4 air conduction and speech discrimination tests (Kockoff's tests) *(See para D1.13 of explanatory notes to this Category)* **Fee:** $99.85	**Benefit:** 75% = $74.90	85% = $84.90
11324	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $28.40	**Benefit:** 75% = $21.30	85% = $24.15
11327	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $17.10	**Benefit:** 75% = $12.85	85% = $14.55
11330	IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner - 1 examination in any 4 week period **Fee:** $6.85	**Benefit:** 75% = $5.15	85% = $5.85
11332	OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to one or more of the following factors:- (i) admission to a neonatal intensive care unit; or (ii) family history of hearing impairment; or (iii) intra-uterine or perinatal infection (either suspected or confirmed); or (iv) birthweight less than 1.5kg; or (v) craniofacial deformity: or (vi) birth asphyxia; or (vii) chromosomal abnormality, including Down's Syndrome; or (viii) exchange transfusion; and where:- - the patient is referred by another medical practitioner; and - middle ear pathology has been excluded by specialist opinion *(See para D1.14 of explanatory notes to this Category)* **Fee:** $50.65	**Benefit:** 75% = $38.00	85% = $43.10
11333	CALORIC TEST OF LABYRINTH OR LABYRINTHS **Fee:** $38.60	**Benefit:** 75% = $28.95	85% = $32.85
11336	SIMULTANEOUS BITHERMAL CALORIC TEST OF LABYRINTHS **Fee:** $38.60	**Benefit:** 75% = $28.95	85% = $32.85
11339	ELECTRONYSTAGMOGRAPHY **Fee:** $38.60	**Benefit:** 75% = $28.95	85% = $32.85
	SUBGROUP 4 - RESPIRATORY		
11500	BRONCHOSPIROMETRY, including gas analysis **Fee:** $144.55	**Benefit:** 75% = $108.45	85% = $122.90

I 11503	MEASUREMENT OF THE MECHANICAL OR GAS EXCHANGE FUNCTION OF THE RESPIRATORY SYSTEM, OR OF RESPIRATORY MUSCLE FUNCTION, OR OF VENTILATORY CONTROL MECHANISMS, using measurements of various parameters including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood, electrical activity of muscles (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed, not being a service associated with a service to which item 22018 applies *(See para D1.15 of explanatory notes to this Category)* **Fee:** $120.00 **Benefit:** 75% = $90.00 85% = $102.00
11506	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator - each occasion at which 1 or more such tests are performed **Fee:** $17.75 **Benefit:** 75% = $13.35 85% = $15.10
11509	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex respiratory function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed **Fee:** $30.85 **Benefit:** 75% = $23.15 85% = $26.25
11512	CONTINUOUS MEASUREMENT OF THE RELATIONSHIP BETWEEN FLOW AND VOLUME DURING EXPIRATION OR INSPIRATION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex lung function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed **Fee:** $53.45 **Benefit:** 75% = $40.10 85% = $45.45
	SUBGROUP 5 - VASCULAR
11600	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - each day of monitoring for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies and where not performed in association with the administration of anaesthesia) (Anaes.) **Fee:** $59.95 **Benefit:** 75% = $45.00 85% = $51.00
11602	INVESTIGATION OF VENOUS REFLUX OR OBSTRUCTION in one or more limbs at rest by CW Doppler or pulsed Doppler involving examination at multiple sites along the limb(s) using intermittent limb compression and/or Valsava manoeuvres to detect prograde and retrograde flow, not being a service associated with a service to which item 32500 or 32501 applies - hard copy trace and report, maximum of two examinations in a 12 month period. *(See para D1.16 of explanatory notes to this Category)* **Fee:** $49.95 **Benefit:** 75% = $37.50 85% = $42.50
11604	PLETHYSMOGRAPHIC ASSESSMENT OF CHRONIC VENOUS DISEASE, assessment of chronic venous disease in the lower and upper extremities, or in the lower or upper extremities (unilateral or bilateral) using venous occlusion plethysmography, strain gauge plethysmography or air plethysmography, not being a service associated with a service to which item 32500 or 32501 applies - examination hard copy trace and report. *(See para D1.16 of explanatory notes to this Category)* **Fee:** $65.55 **Benefit:** 75% = $49.20 85% = $55.75
11605	INFRARED PHOTOPLETHYSMOGRAPHIC ASSESSMENT OF COMPLEX CHRONIC LOWER LIMB VENOUS DISEASE, assessment of chronic venous disease in the lower extremities (unilateral or bilateral) using infrared photoplethysmography, examination during and following exercise with and without superficial venous occlusion, to assess venous function (reflux and/or obstruction) to determine surgical intervention or the conservative management of deep venous thrombotic disease, not being a service associated with a service to which item 32500 or 32501 applies - hard copy trace, calculation of 90% Recovery time and report. *(See para D1.16 of explanatory notes to this Category)* **Fee:** $65.55 **Benefit:** 75% = $49.20 85% = $55.75
11610	MEASUREMENT OF ANKLE: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease, examination, hard copy trace and report. *(See para D1.17 of explanatory notes to this Category)* **Fee:** $55.15 **Benefit:** 75% = $41.40 85% = $46.90

11611	MEASUREMENT OF WRIST: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of radial and ulnar (or finger) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of the wrist (or finger) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of upper extremity arterial disease, examination, hard copy trace and report. *(See para D1.17 of explanatory notes to this Category)* **Fee:** $55.15 **Benefit:** 75% = $41.40 85% = $46.90
11612	EXERCISE STUDY FOR THE EVALUATION OF LOWER EXTREMITY ARTERIAL DISEASE, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices for the evaluation of lower extremity arterial disease at rest and following exercise using a treadmill or bicycle ergometer or other such equipment where the exercise workload is quantifiably documented, examination and report. **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
11614	TRANSCRANIAL DOPPLER, examination of the intracranial arterial circulation using CW Doppler or pulsed Doppler with hard copy recording of waveforms, examination and report, not associated with a service to which item 55280 applies. *(See para D1.17 of explanatory notes to this Category)* **Fee:** $65.55 **Benefit:** 75% = $49.20 85% = $55.75
11615	MEASUREMENT OF DIGITAL TEMPERATURE, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing. **Fee:** $65.65 **Benefit:** 75% = $49.25 85% = $55.85
11627	PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age **Fee:** $197.90 **Benefit:** 75% = $148.45 85% = $168.25
	SUBGROUP 6 - CARDIOVASCULAR
11700	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report *(See para D1.18 of explanatory notes to this Category)* **Fee:** $27.05 **Benefit:** 75% = $20.30 85% = $23.00
11701	TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion *(See para D1.19 of explanatory notes to this Category)* **Fee:** $13.45 **Benefit:** 75% = $10.10 85% = $11.45
11702	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only **Fee:** $13.45 **Benefit:** 75% = $10.10 85% = $11.45
11708	CONTINUOUS ECG RECORDING of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), NOT IN ASSOCIATION WITH AMBULATORY BLOOD PRESSURE MONITORING, involving microprocessor based analysis equipment, interpretation and report of recordings by a specialist physician or consultant physician, not being a service to which item 11709 applies *(See para D1.20 of explanatory notes to this Category)* **Fee:** $110.70 **Benefit:** 75% = $83.05 85% = $94.10
11709	CONTINUOUS ECG RECORDING (Holter) of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), NOT IN ASSOCIATION WITH AMBULATORY BLOOD PRESSURE MONITORING, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, with interpretation and report by a specialist physician or consultant physician *(See para D1.20 of explanatory notes to this Category)* **Fee:** $144.95 **Benefit:** 75% = $108.75 85% = $123.25
11710	AMBULATORY ECG MONITORING, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $44.90 **Benefit:** 75% = $33.70 85% = $38.20
11711	AMBULATORY ECG MONITORING for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $24.45 **Benefit:** 75% = $18.35 85% = $20.80

11712	MULTI CHANNEL ECG MONITORING AND RECORDING during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG, and with or without continuous blood pressure monitoring and the recording of other parameters, on premises equipped with mechanical respirator and defibrillator **Fee:** $131.65 **Benefit:** 75% = $98.75 85% = $111.95
11713	SIGNAL AVERAGED ECG RECORDING involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including anal ysis, interpretation and report of recording by a specialist physician or consultant physician *(See para D1.21 of explanatory notes to this Category)* **Fee:** $60.35 **Benefit:** 75% = $45.30 85% = $51.30
11715	BLOOD DYE DILUTION INDICATOR TEST **Fee:** $104.55 **Benefit:** 75% = $78.45 85% = $88.90
11718	IMPLANTED PACEMAKER TESTING involving elec trocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700 or 11721 applies **Fee:** $30.05 **Benefit:** 75% = $22.55 85% = $25.55
11721	IMPLANTED PACEMAKER TESTING of atriovent ricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11700 or 11718 applies **Fee:** $60.35 **Benefit:** 75% = $45.30 85% = $51.30
11722	IMPLANTED ECG LOOP RECORDING, for investigation of recurrent unexplained syncope, including re-programming of device, retrieval of stored data, analysis, interpretation and report, not in association with item 38285 **Fee:** $30.05 **Benefit:** 75% = $22.55 85% = $25.55
11724	UP-RIGHT TILT TABLE TESTING for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician - on premises equipped with a mechanical respirator and defibrillator **Fee:** $146.15 **Benefit:** 75% = $109.65 85% = $124.25
	SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL
11800	OESOPHAGEAL MOTILITY TEST, manometric **Fee:** $151.05 **Benefit:** 75% = $113.30 85% = $128.40
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation **Fee:** $151.05 **Benefit:** 75% = $113.30 85% = $128.40
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 10 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 D1.22 of explanatory notes to this Category)* **Fee:** $1,764.85 **Benefit:** 75% = $1,323.65 85% = $1,703.35
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex **Fee:** $161.60 **Benefit:** 75% = $121.20 85% = $137.40
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency **Fee:** $216.15 **Benefit:** 75% = $162.15 85% = $183.75

	SUBGROUP 8 - GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS
11900	URINE FLOW STUDY including peak urine flow measurement, not being a service associated with a service to which item 11919 applies **Fee:** $23.85 **Benefit:** 75% = $17.90 85% = $20.30
11903	CYSTOMETROGRAPHY, not being a service associated with a service to which any of items 11012-11027, 11912, 11915, 11919, 11921 and 36800 or any item in Group I3 applies **Fee:** $96.20 **Benefit:** 75% = $72.15 85% = $81.80
11906	URETHRAL PRESSURE PROFILOMETRY, not being a service associated with a service to which any of items 11012-11027, 11909, 11919, 11921 and 36800 or any item in Group I3 applies **Fee:** $96.20 **Benefit:** 75% = $72.15 85% = $81.80
11909	URETHRAL PRESSURE PROFILOMETRY WITH simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906, 11915, 11919, 36800 or any item in Group I3 applies **Fee:** $142.85 **Benefit:** 75% = $107.15 85% = $121.45
11912	CYSTOMETROGRAPHY with simultaneous measurement of rectal pressure, not being a service associated with a service to which any of items 11012-11027, 11903, 11915, 11919, 11921 and 36800 or any item in Group I3 applies (Anaes.) **Fee:** $142.85 **Benefit:** 75% = $107.15 85% = $121.45
11915	CYSTOMETROGRAPHY with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which any of items 11012-11027, 11903, 11909, 11912, 11919, 11921 and 36800 or any item in Group I3 applies (Anaes.) **Fee:** $142.85 **Benefit:** 75% = $107.15 85% = $121.45
11917	CYSTOMETROGRAPHY IN CONJUNCTION WITH ULTRASOUND OF 1 OR MORE COMPONENTS OF THE URINARY TRACT, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11915, 11919, 11921 and 36800 apply. (Anaes.) **Fee:** $370.65 **Benefit:** 75% = $278.00 85% = $315.10
11919	CYSTOMETROGRAPHY IN CONJUNCTION WITH CONTRAST MICTURATING CYSTOURETHROGRAPHY, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11917, 11921 and 36800 apply (Anaes.) **Fee:** $370.65 **Benefit:** 75% = $278.00 85% = $315.10
11921	BLADDER WASHOUT TEST for localisation of urinary infection not including bacterial counts for organisms in specimens **Fee:** $64.90 **Benefit:** 75% = $48.70 85% = $55.20
	SUBGROUP 9 - ALLERGY TESTING
12000	SKIN SENSITIVITY TESTING for allergens, USING 1 TO 20 ALLERGENS, not being a service associated with a service to which item 12012, 12015, 12018 or 12021 applies **Fee:** $33.70 **Benefit:** 75% = $25.30 85% = $28.65
12003	SKIN SENSITIVITY TESTING for allergens, USING MORE THAN 20 ALLERGENS, not being a service associated with a service to which item 12012, 12015, 12018 or 12021 applies **Fee:** $50.95 **Benefit:** 75% = $38.25 85% = $43.35
12012	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using less than the number of allergens included in a standard patch test battery *(See para D1.23 of explanatory notes to this Category)* **Fee:** $17.95 **Benefit:** 75% = $13.50 85% = $15.30
12015	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery *(See para D1.23 of explanatory notes to this Category)* **Fee:** $54.05 **Benefit:** 75% = $40.55 85% = $45.95
12018	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery and additional allergens to a total of up to and including 50 allergens *(See para D1.23 of explanatory notes to this Category)* **Fee:** $69.60 **Benefit:** 75% = $52.20 85% = $59.20

DIAGNOSTIC		OTHER
12021	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis, performed by or on behalf of a specialist in the practice of his or her specialty, using more than 50 allergens **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70	
	SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	
12200	COLLECTION OF SPECIMEN OF SWEAT by iontophoresis **Fee:** $32.20 **Benefit:** 75% = $24.15 85% = $27.40	
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 or exacerbation of a previous severe psychiatric illness payable once only in any twelve month period. *(See para D1.24 of explanatory notes to this Category)* **Fee:** $2,071.00 **Benefit:** 75% = $1,553.25 85% = $2,009.50	
12203	OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report ; and f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient - payable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period. *(See para D1.25 of explanatory notes to this Category)* **Fee:** $508.90 **Benefit:** 75% = $381.70 85% = $447.40	

DIAGNOSTIC		OTHER
	OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient ***where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12203 applies*** for the adjustment and/or testing of the effectiveness of a *positive pressure ventilatory support device* (other than nasal continuous positive airway pressure) in sleep, in a *patient with severe cardio-respiratory failure,* and where previous studies have demonstrated failure of continuous positive airway pressure or oxygen - **each additional investigation** *(See para D1.25 of explanatory notes to this Category)*	
12207	**Fee:** $508.90 **Benefit:** 75% = $381.70 85% = $447.40	
	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED 0 - 12 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental ⩟ diaphragm, respiratory movement must include rib and abdomen (⩟ sum) airflow detection, measurement of CO_2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. *(See para D1.25 of explanatory notes to this Category)*	
12210	**Fee:** $607.40 **Benefit:** 75% = $455.55 85% = $545.90	
	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED BETWEEN 12 AND 18 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental ⩟ diaphragm, respiratory movement must include rib and abdomen (⩟ sum) airflow detection, measurement of CO_2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. *(See para D1.25 of explanatory notes to this Category)*	
12213	**Fee:** $547.20 **Benefit:** 75% = $410.40 85% = $485.70	

	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED 0 - 12 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental ⊨ diaphragm, respiratory movement must include rib and abdomen (⊨ sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12210 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation. *(See para D1.25 of explanatory notes to this Category)* **Fee:** $607.40 **Benefit:** 75% = $455.55 85% = $545.90
12215	
	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED BETWEEN 12 AND 18 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental ⊨ diaphragm, respiratory movement must include rib and abdomen (⊨ sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12213 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation. *(See para D1.25 of explanatory notes to this Category)* **Fee:** $547.20 **Benefit:** 75% = $410.40 85% = $485.70
12217	
+	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for: . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - **1 service only in a period of 24 months** - including interpretation and report; not being a service associated with a service to which item 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.26 of explanatory notes to this Category)* **Fee:** $88.60 **Benefit:** 75% = $66.45 85% = $75.35
12306	
+	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using quantitative computerised tomography**, for: . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - **1 service only in a period of 24 months** - including interpretation and report; not being a service associated with a service to which item 12306, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.26 of explanatory notes to this Category)* **Fee:** $88.60 **Benefit:** 75% = $66.45 85% = $75.35
12309	

DIAGNOSTIC		OTHER
+ 12312	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; or . female hypogonadism lasting more than 6 months before the age of 45. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 12 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.26 of explanatory notes to this Category)* **Fee:** $88.60 **Benefit:** 75% = $66.45 85% = $75.35	
+ 12315	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 24 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12318 or 12321 applies (Ministerial Determination) *(See para D1.26 of explanatory notes to this Category)* **Fee:** $88.60 **Benefit:** 75% = $66.45 85% = $75.35	
+ 12318	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using quantitative computerised tomography**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; . female hypogonadism lasting more than 6 months before the age of 45; . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 24 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12321 applies (Ministerial Determination) *(See para D1.26 of explanatory notes to this Category)* **Fee:** $88.60 **Benefit:** 75% = $66.45 85% = $75.35	
+ 12321	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the **measurement** of bone density 12 months following a significant change in therapy for: . established low bone mineral density; or . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma. Measurement of 2 or more sites - **1 service only in a period of 12 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12318 applies (Ministerial Determination). *(See para D1.26 of explanatory notes to this Category)* **Fee:** $88.60 **Benefit:** 75% = $66.45 85% = $75.35	

	GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)
12500	BLOOD VOLUME ESTIMATION **Fee:** $187.50 **Benefit:** 75% = $140.65 85% = $159.40
12503	ERYTHROCYTE RADIOACTIVE UPTAKE SURVIVAL TIME TEST OR IRON KINETIC TEST **Fee:** $367.65 **Benefit:** 75% = $275.75 85% = $312.55
12506	GASTROINTESTINAL BLOOD LOSS ESTIMATION involving examination of stool specimens **Fee:** $262.50 **Benefit:** 75% = $196.90 85% = $223.15
12509	GASTROINTESTINAL PROTEIN LOSS **Fee:** $187.50 **Benefit:** 75% = $140.65 85% = $159.40
12512	RADIOACTIVE B12 ABSORPTION TEST 1 isotope **Fee:** $90.90 **Benefit:** 75% = $68.20 85% = $77.30
12515	RADIOACTIVE B12 ABSORPTION TEST 2 isotopes **Fee:** $198.95 **Benefit:** 75% = $149.25 85% = $169.15
12518	THYROID UPTAKE (using probe) **Fee:** $90.90 **Benefit:** 75% = $68.20 85% = $77.30
12521	PERCHLORATE DISCHARGE STUDY **Fee:** $109.60 **Benefit:** 75% = $82.20 85% = $93.20
12524	RENAL FUNCTION TEST (without imaging procedure) **Fee:** $137.00 **Benefit:** 75% = $102.75 85% = $116.45
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) **Fee:** $73.50 **Benefit:** 75% = $55.15 85% = $62.50
12530	WHOLE BODY COUNT not being a service associated with a service to which another item applies **Fee:** $109.60 **Benefit:** 75% = $82.20 85% = $93.20
12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled $^{13}CO_2$ or $^{14}CO_2$, for either:- (a) the confirmation of *Helicobacter pylori* colonisation, where: (i) suitable biopsy material for diagnosis cannot be obtained at endoscopy in patients with peptic ulcer disease, or where the diagnosis of peptic ulcer has been made on barium meal; or (ii) in patients with past history of duodenal ulcer, gastric ulcer or gastric neoplasia, where endoscopy is not indicated, OR (b) the monitoring of the success of eradication of *Helicobacter pylori* in patients with peptic ulcer disease - where any request for the test by another medical practitioner who collects the breath sample specifically identifies in writing one or more of the clinical indications for the test **Fee:** $73.20 **Benefit:** 75% = $54.90 85% = $62.25

THERAPEUTIC PROCEDURES

CATEGORY 3

CATEGORY 3 - THERAPEUTIC PROCEDURES

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CATEGORY 3 - THERAPEUTIC PROCEDURES

EXPLANATORY NOTES

MISCELLANEOUS THERAPEUTIC PROCEDURES (Group T1)

T1.1 Hyperbaric Oxygen Therapy (Items 13020, 13025, 13030)

T1.1.1 Hyperbaric Oxygen Therapy not covered by these items would attract benefits on an attendance basis.

T1.1.2 For the purposes of these items, a comprehensive hyperbaric medicine facility means a separate hospital area that, on a 24 hour basis:

(a) is equipped and staffed so that it is capable of providing to a patient:
- hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (280 kilo pascal gauge pressure); and
- mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment.

(b) is supported by:
- at least one specialist with training in Diving and Hyperbaric Medicine, or medical practitioner who holds the Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society who is rostered and immediately available to the facility during normal working hours;

(c) and is staffed by:
- a registered medical practitioner with training in Diving and Hyperbaric Medicine who is present in the hyperbaric facility and immediately available at all times when patients are undergoing treatment; and
- a registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Oxygen Facility Industry Guidelines (Draft Australian Standard SF346) who is present during hyperbaric oxygen therapy.

(d) has defined admission and discharge policies.

T1.2 Haemodialysis (Items 13100, 13103)

T1.2.1 Item 13100 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in the patient who is not stabilised where the total attendance time by the supervising medical specialist exceeds 45 minutes.

T1.2.2 Item 13103 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in a stabilised patient, or in the case of an unstabilised patient, where the total attendance time by the supervising medical specialist does not exceed 45 minutes.

T1.3 Consultant physician supervision of home dialysis (Item 13104)

T1.3.1 Item 13104 covers the planning and management of dialysis and the supervision of a patient on home dialysis by a consultant physician in the practice of his or her specialty of renal medicine. Planning and management would cover the consultant physician participating in patient management discussions coordinated by renal centres. Supervision of the patient at home can be undertaken by telephone or other electronic medium, and includes:

- Regular ordering, performance and interpretation of appropriate biochemical and haematological studies (generally monthly);
- Feed-back of results to the home patient and his or her treating general physician;
- Adjustments to medications and dialysis therapies based upon these results;
- Co-ordination of regular investigations required to keep patient on active transplantation lists, where relevant;
- Referral to, and communication with, other specialists involved in the care of the patient; and
- Being available to advise the patient or the patient's agent.

A record of the services provided should be made in the patient's clinical notes.

T1.3.2 The fee equates to one hour of time spent undertaking these activities. It is expected that the item will be claimed once per month, to a maximum of 12 claims per year. The patient should be informed that he or she will incur a charge for which a Medicare rebate will be payable.

T1.3.3 This item includes dialysis conducted in a residential aged care facility. In remote areas, where a patient's home is an unsuitable environment for home dialysis due to a lack of space, or the absence of telecommunication, electricity and water utilities, the item includes dialysis in a community facility such as the local primary health care clinic.

T1.4 Assisted Reproductive Services (Items 13200 - 13221)

T1.4.1 Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule (including Pathology) in lieu of or in conjunction with Items 13200 - 13221. Specifically, Medicare benefits are not payable for Items 13200 - 13221 in association with Item 104, 105, 14203, 14206, 35637, 66695 - 66713 or 73521 - 73529. Items 14203 and 14206 are not payable for artificial insemination.

T1.4.2 A treatment cycle is a series of treatment for the purposes of in vitro fertilisation (IVF), gamete intrafallopian transfer (GIFT) or similar procedures and is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending not more than 30 days later.
T1.4.3 The date of service in respect of treatment covered by Items 13200, 13203, 13206, 13209 and 13218 is **DEEMED** to be the **FIRST DAY** of the treatment cycle, except in the case of Item 13218 where the service is provided to a patient in hospital. In this case, the account should separately identify the actual date of the service.
T1.4.4 For treatment covered by Items 13200, 13203, 13206 and 13218 the account must be provided by the gynaecologist supervising the treatment cycle.
T1.4.5 Embryology laboratory services covered by Items 13200 and 13206 include egg recovery from aspirated follicular fluid, insemination, monitoring of fertilisation and embryo development, and preparation of gametes or embryos for transfer and freezing. It does not include semen preparation.
T1.4.6 Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.
T1.4.7 Items 13200, 13206, 13215 and 13218 do not include services provided in relation to artificial insemination using the husband's or donated sperm.
T1.4.8 Items 13200 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify Medicare Australia of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these two items.

T1.5 Administration of Blood or Bone Marrow already Collected (Item 13706)
T1.5.1 Item 13706 is payable for the transfusion of blood, or platelets or white blood cells or bone marrow or gamma globulins. This item is not payable when gamma globulin is administered intramuscularly.

T1.6 Collection of Blood (Item 13709)
T1.6.1 Medicare benefits are payable under Item 13709 for collection of blood for autologous transfusions in respect of an impending operation (whether or not the blood is used), or when homologous blood is required in an emergency situation.
T1.6.2 Benefits are not payable under Item 13709 for collection of blood for long-term storage for possible future autologous transfusion, or for other forms of directed blood donation.

T1.7 Intensive Care Units (ICU)
T1.7.1 'Intensive Care Unit' means a separate hospital area that:
(a) is equipped and staffed so as to be capable of providing to a patient:
(i) mechanical ventilation for a period of several days; and
(ii) invasive cardiovascular monitoring; and
(b) is supported by:
(i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and
(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
(iii) a registered nurse for at least 18 hours in each day; and
(c) has defined admission and discharge policies.
T1.7.2 For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that:
(a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:
(i) mechanical ventilation for a period of several days; and
(ii) invasive cardiovascular monitoring; and
(b) is supported by:
(i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available and exclusively rostered to the ICU during normal working hours; and
(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
(iii) a registered nurse for at least 18 hours in each day; and
(c) has defined admission and discharge policies.
T1.7.3 In respect to T1.7.1(b)(i) above:
(a) “immediately available” means that the intensivist must be predominantly present in the ICU during normal working hours. Reasonable absences from the ICU would be acceptable to attend conferences, meetings and other commitments which might involve absences of up to 2 hours during the working day; and
(b) “exclusively rostered” means that the specialist’s sole clinical commitment is to intensive care associated activities and is not involved in any other duties that may preclude immediate availability to intensive care if required..
T1.7.4 Medicare benefits are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day. However, benefits are also payable for an attendance by another specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where

appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract benefits in addition to the intensive care items.

T1.7.5 In respect of Neonatal Intensive Care Units, as defined above, benefits are payable for admissions of babies who meet the following criteria:-

(i) all babies weighing less than 1000gms;
(ii) all babies with an endotracheal tube, and for the 24 hours following endotracheal tube removal;
(iii) all babies requiring Constant Positive Airway Pressure (CPAP) for acute respiratory instability;
(iv) all babies requiring more than 40% oxygen for more than 4 hours;
(v) all babies requiring an arterial line for blood gas or pressure monitoring; or
(vi) all babies having frequent seizures.

T1.7.6 Cases may arise where babies admitted to a Neonatal Intensive Care Unit under the above criteria who, because they no longer satisfy the criteria are ready for discharge, in accordance with accepted discharge policies, but who are physically retained in the Neonatal Intensive Care Unit for other reasons. For benefit purposes such babies must be deemed as being discharged from the Neonatal Intensive Care Unit and not eligible for benefits under items 13870, 13873, 13876, 13881, 13882, 13885 and 13888.

T1.7.7 Likewise, benefits are not payable under items 13870, 13873, 13876, 13881 13882, 13885 and 13888 in respect of babies not meeting the above criteria, but who, for whatever other reasons, are physically located in a Neonatal Intensive Care Unit.

T1.7.8 Benefits are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

T1.8 Procedures Associated with Intensive care (Items 13818, 13842, 13847, 13848, 13857)

T1.8.1 Item 13818 covers the insertion of a right heart balloon catheter (Swan-Ganz catheter). Benefits are payable under this item only once per day except where a second discrete operation is performed on that day.

T1.8.2 Benefits for monitoring of pressures, up to a maximum of 4 on one day, are payable under Item 11600 outside of an ICU and Item 13876 within an ICU. Benefits are payable under items 13876 and 11600 once only for each type of pressure in the one day up to a maximum of 4 pressures.

T1.8.3 If a service covered by Item 13842 is provided outside of an ICU, in association with, for example, an anaesthetic, benefits are payable for Item 13842 in addition to Item 13870 where the services are performed on the same day. Where this occurs, accounts should be endorsed "performed outside of an Intensive Care Unit" against Item 13842.

T1.8.4 Item 13847 covers management of counterpulsation by intraaortic balloon on the first day and includes initial and subsequent consultations and monitoring of parameters. Insertion of the intraaortic balloon is covered under item 38606 Management on each day subsequent to the first is covered under item 13848.

(a) “management” of counterpulsation of intraaortic balloon means full heamodynamic assessment and management on several occasions during the day.

T1.8.5 Item 13857 covers the establishment of airway access and initiation of ventilation on a patient outside intensive care for the purpose of subsequent ventilatory support in intensive care. Benefits are not payable under Item 13857 where airway access and ventilation is initiated in the context of an anaesthetic for surgery even if it is likely that following surgery the patient will be ventilated in an ICU. In such cases the appropriate anaesthetic item/s should be itemised.

T1.8. 6 Medicare benefits are not payable for sampling by arterial puncture under Item 13839 in addition to Item 13870 (and 13873) on the same day. Benefits are payable under Item 13842 (Intra-arterial cannulation) in addition to Item 13870 (and 13873) when performed on the same day.

T1.9 Management and Procedures in Intensive Care Unit

T1.9.1 Medicare benefits are only payable for management and procedures in intensive care covered by items 13870, 13873, 13876, 13882, 13885 and 13888 where the service is provided by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care (see note T1.7.3 (a) and (b))

Items 13870 and 13873

T1.9.2 Medicare Benefits Schedule fees for Items 13870 and 13873 represent global daily fees covering all attendances by the intensivist in the ICU (and attendances provided by support medical personnel) and all electrocardiographic monitoring, arterial sampling and, bladder catheterisation.performed on the patient on the one day. If a patient is transferred from one ICU to another it would be necessary for an arrangement to be made between the two ICUs regarding the billing of the patient.

T1.9. 3 Items 13870 and 13873 should be itemised on accounts according to each calendar day and not per 24 hour period. For periods when patients are in an ICU for very short periods (say less than 2 hours) with minimal ICU management during that time, a fee should not be raised.

Item 13876

T1.9. 4 Item 13876 covers the monitoring of pressures in an ICU.

T1.9. 5 Benefits are attracted under Item 13876 only once for each type of pressure on the one day, (up to a maximum of 4 pressures) irrespective of the number of medical practitioners involved in the monitoring of pressures in an ICU.

T1.9. 6 Benefits are payable under item 11600 where monitoring occurs outside the ICU by practitioners not associated with the ICU. Benefits are attracted under item 11600 only once for each type of pressure on the one day (up to a maximum of 4 pressures) irrespective of the number of practitioners involved in monitoring the pressures.

T1.10 Implanted Pump or Reservoir/Drug Delivery Device (Items 13939 and 13942)

T1.10.1 The fee for Items 13939 and 13942 includes a component to cover accessing of the drug delivery device. Accordingly, benefits are not payable under Item 13945 (Long-term implanted drug delivery device, accessing of) in addition to Items 13939 and 13942.

T1.11 PUVA or UVB Therapy (Items 14050, 14053)

T1.11.1 A component for any necessary subsequent consultation has been included in the Schedule fee for these items. However, the initial consultation preceding commencement of a course of therapy would attract benefits.

T1.12 Laser Photocoagulation (Items 14106 - 14124)

T1.12.1 The Australasian College of Dermatologists has advised that the following ranges (applicable to an average 4 year old child and an adult) should be used as a reference to the treatment areas specified in Items 14106 - 14124:

Entire forehead	50 -75 cm^2
Cheek	55 - 85 cm^2
Nose	10 -25 cm^2
Chin	10 - 30 cm^2
Unilateral midline anterior - posterior neck	60 - 220 cm^2
Dorsum of hand	25 - 80 cm^2
Forearm	100 - 250 cm^2
Upper arm	105 - 320 cm^2

T1.12.2 Item 14124 applies where additional treatments are indicated in a 12 month period and are only claimable for haemangiomas of infancy.

RADIATION ONCOLOGY (Group T2)

T2.1 General

T2.1.1 The level of benefits for radiotherapy depends not only on the number of fields irradiated but also on the frequency of irradiation. In the items related to additional fields, it is to be noted that treatment by rotational therapy is considered to be equivalent to the irradiation of three fields (i.e., irradiation of one field plus two additional fields). For example, each attendance for orthovoltage rotational therapy at the rate of 3 or more treatments per week would attract benefit under Item 15100 plus twice Item 15103.

T2.1.2 Benefits are attracted for an initial referred consultation and radiotherapy treatment where both take place at the same attendance.

T2.2 Planning Services (Items 15500 - 15536)

T2.2.1 A planning episode involves field setting (ie simulation or localisation) and dosimetry (either using a CT interfacing planning computer or a non-CT interfacing planning computer). One plan only will attract Medicare benefits in a course of treatment. However, where a plan for brachytherapy is undertaken in association with a plan for megavoltage or teletherapy treatment, benefits would be attracted for both services.

T2.2.2 Medicare benefits are attracted for an initial referred consultation and computerised planning where both take place at the same attendance. However, benefits are not payable for subsequent consultations rendered in association with therapy or planning services in the same course of treatment. Benefits are also payable, under the appropriate radiology item in Group I3, in respect of verification films (or port films) taken during the course of treatment.

T2.3 Brachytherapy of the Prostate (Item 15338)

T2.3.1 Brachytherapy treatment is only recommended for patients with a gland volume of less than or equal to 40cc and who have a life expectancy of at least 10 years.

T2.3.2 An approved site is one that has been licensed by the relevant Radiation Advisory Body.

T2.4 Intravascular Brachytherapy for Coronary Artery Restenoses (items 15360, 15363 and 15541)

T2.4.1 These items were introduced into the Schedule on an interim basis, following a recommendation from the Medical Services Advisory Committee (MSAC). Interim funding is provided for a period of 3 years, from 1 November 2003 to 31 October 2006, pending further assessment of the long-term safety, efficacy and cost-effectiveness of the procedure, and the impact of emerging technologies such as drug-eluting stents. Further information on the review of these items is available from the MSAC Secretariat (see para 8.4 of the General Explanatory Notes).

OBSTETRICS (Group T4)

T4.1 Antenatal Care (Item 16500)

T4.1.1 In addition to routine antenatal attendances covered by Item 16500 the following services, where rendered during the antenatal period, attract benefits:-

(a) Items 16501, 16502, 16504, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514 and 16600 to 16636.
(b) The initial consultation at which pregnancy is diagnosed.
(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
(e) Treatment of an intercurrent condition not directly related to the pregnancy.

T4.1.2 Item 16504 relates to the treatment of habitual miscarriage by injection of hormones. A case becomes one of habitual miscarriage following two consecutive spontaneous miscarriages or where progesterone deficiency has been proved by hormonal assay of cells obtained from a smear of the lateral vaginal wall.

T4.1.3 Item 16514 relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the labour and delivery.

T4.2 External Cephalic Version for Breech Presentation (Item 16501)

T4.2.1 Contraindications for this item are as follows:

- antepartum haemorrhage (APH)
- multiple pregnancy,
- fetal anomaly,
- intrauterine growth retardation (IUGR),
- caesarean section scar,
- uterine anomalies,
- obvious cephalopelvic disproportion,
- isoimmunization,
- pre-mature rupture of the membranes.

T4.3 Labour and Delivery (Items 16515, 16518, 16519, 16525)

T4.3.1 Benefits for management of labour and delivery covered by Items 16515, 16518, 16519 and 16525 includes the following (where indicated):-

- surgical and/or intravenous infusion induction of labour;
- forceps or vacuum extraction;
- evacuation of products of conception by manual removal (not being an independent procedure);
- episiotomy or repair of tears.

T4.3.2 Item 16519 covers delivery by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of delivery by Caesarean section, whether because of an emergency situation or otherwise, then Item 16520 would be the appropriate item.

T4.3.3 In some instances the obstetrician may not be able to be present at all stages of confinement. In these circumstances, Medicare benefits are payable under Item 16519 provided that the doctor attends the patient as soon as possible during the confinement and assumes full responsibility for the mother and baby.

T4.3.4 Two items in Group T9 provide benefits for assistance by a medical practitioner at a Caesarean section. Item 51306 relates to those instances where the Caesarean section is the only procedure performed, while Item 51309 applies when other operative procedures are performed at the same time.

T4.3.5 As a rule, 24 weeks would be the period distinguishing a miscarriage from a premature confinement. However, if a live birth has taken place before 24 weeks and the foetus survives for a reasonable period, benefit would be payable under the appropriate confinement item.

T4.3.6 Where, during labour, a medical practitioner hands the patient over to another medical practitioner, benefits are payable under Item 16518 for the referring practitioner's services. The second practitioner's services would attract benefits under Item 16515 (i.e., management of vaginal delivery) or Item 16520 (Caesarean section). If another medical practitioner is called in for the management of the labour and delivery, benefits for the referring practitioner's services should be assessed under Item 16500 for the routine antenatal attendances and on a consultation basis for the postnatal attendances, if performed.

T4.3.7 At a high risk delivery benefits will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the delivery) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk deliveries include cases of difficult vaginal delivery, Caesarean section or the delivery of babies with Rh problems and babies of toxaemic mothers.

T4.4 Caesarean Section (Item 16520)

T4.4.1 Benefits under this item are attracted only where the patient has been specifically referred to another medical practitioner for the management of the delivery by Caesarean section and the practitioner carrying out the procedure has not rendered any antenatal care. Caesarean sections performed in any other circumstances attract benefits under Item 16519.

T4.5 Complicated Confinement (Item 16522)

T4.5.1 Conditions that pose a significant risk of maternal death referred to in Item 16522 include:

- severe pre-eclampsia as defined in the Consensus Statement on the Management of Hypertension in Pregnancy, published in the Medical Journal of Australia, Volume 158 on 17 May 1993, and as revised;
- cardiac disease (co-managed with a consultant physician or a specialist physician);
- coagulopathy;
- severe autoimmune disease;
- previous organ transplant; or
- pre-existing renal or hepatic failure.

T4.6 Post-Partum Care (Items 16564-16573)

T4.6.1 The Schedule fees and benefits payable for Items 16519 and 16520 cover all postnatal attendances on the mother and the baby, except in the following circumstances:-

(i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;

(ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);

(iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over <u>while in labour</u> from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the delivery;

(iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;

(v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

T4.6.2 Normal postnatal care by a medical practitioner would include:-

(i) uncomplicated care and check of:
- lochia
- fundus
- perineum and vulva/episiotomy site
- temperature
- bladder/urination
- bowels

(ii) advice and support for establishment of breast feeding

(iii) psychological assessment and support

(iv) Rhesus status

(v) Rubella status and immunisation

(vi) contraception advice/management

T4.6.3 Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract benefits.

T4.6.4 Items 16564 to 16573 relate to postnatal complications and should not be itemised in respect of a normal delivery. To qualify for benefits under these items, the patient is required to be transferred to theatre, or be administered general anaesthesia or epidural injection for the performance of the procedure. Utilisation of the items will be closely monitored to ensure appropriate usage.

T4.7 Interventional Techniques (16600-16636)

T4.7.1 For Items 16600 to 16636, 35518 and 35674 there is no component in the Schedule fee for the associated ultrasound. Benefits are attracted for the ultrasound under the appropriate items in Group I1 of the Diagnostic Imaging Services Table. If diagnostic ultrasound is performed on a separate occasion to the procedure, benefits would be payable under the appropriate ultrasound item.

T4.7.2 Item 51312 provides a benefit for assistance by a medical practitioner at interventional techniques covered by Items 16606, 16609, 16612, 16615, 16627 and 16633.

EXAMINATION BY AN ANAESTHETIST (Group T6)

T6.1 Pre-anaesthetic Consultations

T6.1.1 Before a procedure is decided upon, a practitioner may refer a patient to a specialist anaesthetist for a pre-anaesthesia consultation. Such an attendance will attract benefit as follows:-

(i) if, as a result of the consultation, anaesthesia and surgery proceeded in the ordinary way, then Item 17603 applies;

(ii) if, as a result of the consultation, the procedure is contra-indicated or is postponed for some days or weeks, this consultation, and any subsequent consultation by the anaesthetist during the postponement period, attracts benefits under the appropriate attendance item. In such a case, to qualify for the specialist rate of benefit, the patient must present a letter or note of referral by the referring doctor.

REGIONAL OR FIELD NERVE BLOCKS (Group T7)

T7.1 General

T7.1.1 A nerve block is interpreted as the anaesthetising of a substantial segment of the body innervated by a large nerve or an area supplied by a smaller nerve where the technique demands expert anatomical knowledge and a high degree of precision.

T7.1.2 Where anaesthesia combines a regional nerve block with general anaesthesia for an operative procedure, benefit will be paid only under the relevant anaesthesia item as set out in Group T10.

T7.1.3 Where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block attracts benefits under the Group T10 anaesthesia item and not the block item in Group T7.

T7.1.4 Where a regional or field nerve block which is covered by an item in Group T7 is administered by a medical practitioner in the course of a surgical procedure undertaken by that practitioner, then such a block will attract benefit under the appropriate Group T7 item.

T7.1.5 When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

T7.1.6 Digital ring analgesia, local infiltration into tissue surrounding a lesion or paracervical (uterine) analgesia are not eligible for the payment of Medicare benefits under items within Group T7. Where procedures are carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure.

T7.2 Maintenance of Regional or Field Nerve Block (Items 18222, 18225)

T7.2.1 Medicare benefit is attracted under these items only when the service is performed other than by the operating surgeon. This does not preclude benefits for an obstetrician performing an epidural block during labour.

T7.2.2 When the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare. In these circumstances a Medicare benefit is not attracted.

T7.3 Intrathecal or Epidural Injection (Item 18232)

T7.3.1 This items covers caudal infusion/injection.

T7.4 Intrathecal and Epidural Infusion

T7.4.1 Items 18226 and 18227 apply where intrathecal or epidural analgesia is required for obstetric patients in the after hours period. For these items, the after hours period is defined as the period from 8pm to 8am on any weekday, or any time on a Saturday, Sunday or a public holiday.

T7.4.2 Medicare benefits are only payable under item 18227 where more than 50% of the service is provided in the after hours period, benefits would be payable under item 18219.

T7.5 Regional or Field Nerve Blocks (Items 18234 - 18288)

T7.5.1 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.

T7.5.2 Paravertebral nerve block items 18274 and 18276 cover the provision of regional anaesthesia for surgical and related procedures for the management acute pain or of chronic pain related to radiculopathy. Infiltration of the soft tissue of the paravertebral area for the treatment of other pain symptoms does not attract benefit under these items. Additionally, items 18274 and 18276 do not cover facet joint blocks/injections. This procedure is covered under item 39013.

SURGICAL OPERATIONS (Group T8)

T8.1 General

T8.1.1 Many items in Group T8 of the Schedule are qualified by one of the following phrases:

"as an independent procedure";

"not being a service associated with a service to which another item in this Group applies"; or

"not being a service to which another item in this Group applies"

An explanation of each of these phrases is as follows.

T8.2 As an Independent Procedure

T8.2.1 The inclusion of this phrase in the description of an item precludes payment of benefits when:-

(i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose;

(ii) such procedure is combined with another in the same body area, e.g. direct examination of larynx (Item 41846) with another operation on the larnyx or trachea;

(iii) the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item 30067/30068) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

T8.3 Not Being a Service Associated with a Service to which another Item in this Group Applies

T8.3.1 "Not being a service associated with a service to which another item in this Group applies" means that benefit is not payable for any other item in that Group when it is performed on the same occasion as this item. eg item 30106.

T8.3.2 "Not being a service associated with a service to which Item ..... applies" means that when this item is performed on the same occasion as the reference item no benefit is payable. eg item 39330.

T8.4 Not Being a Service to which another Item in this Group Applies

T8.4.1 "Not being a service to which another item in this Group applies" means that this item may be itemised if there is no specific item relating to the service performed, e.g. Item 30387 (Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies). Benefits may be attracted for an item with this qualification as well as benefits for another service during the course of the same operation.

T8.5 Multiple Operation Formula

T8.5.1 The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion (except as provided in paragraph T8.5.3) are calculated by the following rule:-

100% for the item with the greatest Schedule fee
plus 50% for the item with the next greatest Schedule fee
plus 25% for each other item.

Note:

(a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.

(b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

(c) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

(d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

T8.5.2 This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.

T8.5.3 Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined in paragraph T8.5.1 would apply in respect of the services performed by each medical practitioner.

T8.5.4 If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

T8.5.5 There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that they would always be subject to the "multiple operation rule".

T8.5.6 Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see paragraph T8.5, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

T8.6 Procedure Performed with Local Infiltration or Digital Block

T8.6.1 It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

T8.7 Aftercare (Post-operative Treatment)

T8.7.1 Section 3(5) of the Health Insurance Act states that services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient (for the purposes of this book, post-operative treatment is generally referred to as "after-care"). However, it should be noted that in some instances the after-care component has been specifically excluded from the item and this is indicated in the description of the

item. In such cases benefits would be payable on an attendance basis where post-operative treatment is necessary. In other cases, where there may be doubt as to whether an item actually does include the after-care, this fact has been reinforced by the inclusion of the words "including after-care" in the description of the item.

T8.7.2 After-care is deemed to include all post-operative treatment rendered by medical practitioners and need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

T8.7.3 The amount and duration of after-care consequent on an operation may vary between patients for the same operation, as well as between different operations which range from minor procedures performed in the medical practitioner's surgery, to major surgery carried out in hospital. As a guide to interpretation, after-care includes all attendances until recovery from the operation (fracture, dislocation etc.) plus the final check or examination, regardless of whether the attendances are at the hospital, rooms, or the patient's home.

T8.7.4 Attendances which form part of after-care, whether at hospitals, rooms, or at the patient's home, should not be shown on the doctor's account. When additional services are itemised, the doctor should show against those services on the account the words "not normal after-care", with a brief explanation of the reason for the additional services.

T8.7.5 Some minor operations are merely stages in the treatment of a particular condition. Attendances subsequent to such operations should not be regarded as after-care but rather as a continuation of the treatment of the original condition and attract benefits. Items to which this policy applies are Items 30219, 30223, 32500, 34521, 34524, 38406, 38409, 39015, 41626, 41656, 42614, 42644, 42650 and 47912. Likewise, there are a number of services which may be performed during the aftercare period of procedures for pain relief which would also attract benefits. Such services would include all items in Groups T6 and T7 and Items 39013, 39100, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

T8.7.6 Where a patient has been operated on in a recognised hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act), and where aftercare is directly related to the episode of admitted care for which the patient was treated free of charge as a public patient, the aftercare should be provided free of charge as part of the public hospital service. However, post-operative attendances by a private medical practitioner at a place other than the hospital may attract Medicare benefits on an attendance basis, subject to the hospital meeting its responsibilities under the 2003-2008 Australian Health Care Agreements relating to the provision of public hospital services.

T8.7.7 When a surgeon delegates after-care to a local doctor, Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the after-care. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.

T8.7.8 Where an initial or subsequent consultation relates to the assessment and discussion of options for treatment and a cosmetic or other non-rebateble services is discussed, this would be considered a rebateable service under Medicare;

Where a consultation relates entirely to a cosmetic or other non-Medicare rebateable service (either before or after that service has taken place), then that consultation is not rebateable under Medicare; and

Any aftercare associated with a cosmetic or non-Medicare rebateable service is also not rebateable under Medicare.

T8.7.9 In respect of fractures, where the after-care is delegated to a doctor at a place other than the place where the initial reduction is carried out, benefit may be apportioned on a 50:50 basis rather than on the 75:25 basis suggested for surgical operations.

T8.7.10 Where the reduction of a fracture is carried out by hospital staff in the out-patient or casualty department of a recognised hospital and the patient is then referred to a private practitioner for supervision of the after-care, Medicare benefits are payable for the after-care treatment on an attendance basis.

T8.7.11 The following table shows the period which has been adopted as reasonable for the after-care of fractures:-

(Note: This list is a guide only and each case should be judged on individual merits. See paragraphs T8.7.2 to T8.7.4 above.)

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
Femur	6 months
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months
Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks
Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

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

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

T8.9 Abandoned Surgery (Item 30001)

T8.9.1 Item 30001 applies where the procedure has been commenced but is then discontinued for medical reasons or for other reasons which are beyond the surgeon's control (eg equipment failure). Claims for benefits under this item should be submitted to Medicare for approval of benefits and should include full details of the circumstances of the operation, including details of the surgery which had been proposed and the reasons for the operation being discontinued.

T8.9.2 Where an abandoned procedure eligible for a benefit under item 30001 attracts an assistant under the provisions of the items listed in Group T9 (Assistance at Operations), the fee for the surgical assistant is calculated as 50% of the assistance fee that would have applied under the relevant item from Group T9.

T8.9.3 Practitioners claiming an assistant fee for abandoned surgery should itemise their accounts with the relevant item from group T9. Such claims should include an account endorsement "assistance at abandoned surgery" or similar and should be accompanied by full clinical details of the circumstances of the operation, including details of the surgery proposed and the reasons for the operation being discontinued.

T8.10 Repair of Wound (Items 30023 - 30049)

T8.10.1 The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items do not cover repair of wound at time of surgery.

T8.10.2 Item 30023 covers debridement of traumatic, “deep and extensively contaminated” wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

T8.10.3 For the purpose of items 30026 to 30049 the term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.

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 (including shave) of a lesion is required to confirm a diagnosis and would facilitate the appropriate management of that lesion. If the shave biopsy results in a definitive excision of the lesion, only 30071 can be claimed.

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

T8.12 Lipectomy (Item 30165 to 30177)

T8.12.1 Multiple lipectomies, e.g., both buttocks and both thighs attract benefits under Item 30171 once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction, except in the circumstances outlined in Items 45584 and 45585.

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

T8.12.3 Lipectomy items 30165 to 30177 cannot be claimed in association with items 45564, 45565 or 45530. Where the abdomen requires closure with reconstruction of the umbilicus following free tissue transfer (45564, 45565) or breast reconstruction (45530), item 30178 is to be claimed.

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 fewer 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.

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

T8.14.1 In Items 30196 and 30197, serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

T8.14.2 For the purposes of Items 30196 to 30203 (inclusive), the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

T8.14.3 For the purposes of items 30196 to 30203 (inclusive), an anatomical region is defined as: hand, forearm, upper arm, shoulder, upper trunk or chest (anterior and posterior), lower trunk (anterior or posterior) or abdomen (anterior lower trunk), buttock, genital area/perineum, upper leg, lower leg and foot, neck, face (six sections: left/right lower, left/right mid and left/right upper third) and scalp.

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.)

T8.16 Sentinel node biopsy for breast cancer

T8.16.1 The Medical Services Advisory Committee (MSAC) evaluated the available evidence and found that sentinel lymph node biopsy is safe and effective in identifying sentinel lymph nodes, but that the long term outcomes of sentinel lymph node biopsy compared to lymph node clearance are uncertain. Medicare funding for these items is available for five years until November 2010, before which time MSAC will review the results of trials conducted in the intervening period.

T8.16.2 For items 30299 and 30300, both lymphoscintigraphy and lymphotropic dye injection must be used, unless the patient has an allergy to the lymphotropic dye.

T8.16.3 For the purposes of these items, the axillary lymph node levels referred to are as follows:

Level I - axillary lymph nodes up to the inferior border of pectoralis minor.

Level II -axillary lymph nodes up to the superior border of pectoralis minor.

Level III - axillary lymph nodes extending above the superior border of pectoralis minor.

T8.17 Dissection of Axillary Lymph Nodes (Items 30335, 30336)

T8.17.1 For the purposes of Items 30335 and 30336, the definitions of lymph node levels referred to are set out below.

T8.17.2 Anatomically, the dissection extends from below upwards as follows:

Level I - dissection of axillary lymph nodes up to the inferior border of pectoralis minor.

Level II – dissection of axillary lymph nodes up to the superior border of pectoralis minor.

Level III - dissection of axillary lymph nodes extending above the superior border of pectoralis minor.

T8.18 Procedures on the Abdominal viscera (Item 30375)

T8.18.1 Procedures on the abdominal viscera may be performed by laparotomy or laparoscopically. Item 30375 covers several operations on abdominal viscera not dissimilar in time and complexity. Where more than one of the procedures are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

T8.19 Major abdominal incision (Item 30396)

T8.19 A major abdominal incision is one that gives access through an open wound to all compartments of the abdominal cavity. Item 30396 is intended for open surgical incisions only and not those performed laparoscopically.

T8.20 Gastrointestinal endoscopic procedures (Items 30473-30481, 30484-30487, 30490-30494, 32084-32095, 32103, 32104 and 32106)

T8.20.1 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

T8.20.2 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 guidelines for the prevention of transmission of infectious diseases in the health care setting', Department Health and Ageing

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

Anaesthetic and resuscitation equipment

T8.20.3 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.

T8.20.4 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).

T8.21 Revision of Gastric reduction, Gastroplasty or bypass

T8.21.1 Revision of gastric procedure, for example to correct misplacement of the gastric band or other adverse effects of the initial surgery, involves complete reversal of the initial surgery immediately followed by another reduction, gastroplasty or bypass procedure. For revision item 30514 can be claimed with either item 30511 or 30512, whichever is relevant. For cases where division of adhesions exceeds 45 minutes either item 30378 (laparotomy) or item 30393 (laparoscopy) can also be claimed.

T8.22 Gastrectomy, Sub-total Radical (Item 30523)

T8.22.1 The item differs from total radical Gastrectomy (Item 30524) in that a small part of the stomach is left behind. It involves resection of the greater omentum and posterior abdominal wall lymph nodes with or without splenectomy.

T8.23 Anti-reflux Operations (Items 30527-30533, 31464, 31466)

T8.23.1 These items cover various operations for reflux oesophagitis. Where the only procedure performed is the simple closure of a diaphragmatic hiatus benefit would be attracted under Item 30387 (Laparotomy involving operation on abdominal viscera, including pelvic viscera, not being a service to which another item in this Group applies).

T8.24 Removal of Skin Lesions (Items 31200 – 31355)

T8.24.1 The excision of warts and seborrheic keratoses attracts benefits on an attendance basis with the exceptions outlined in T8.13 of the explanatory notes to this category. Excision of pre-malignant lesions including solar keratoses where clinically indicated are covered by items 31200 to 31240.

T8.24.2 The excision of suspicious pigmented lesions for diagnostic purposes attract benefits under items 31205 to 31240. Only if a further more extensive excision is undertaken should the items covering excision of malignancies be used.

T8.24.3 Items 31200 and 31245 *do not require* the specimen to be sent for histological confirmation. Items 31205 to 31240 and 31250 *require* that the specimen be sent for histological examination. Items 31255 to 31335 *require* that a specimen has been sent for histological confirmation of malignancy, and any subsequent specimens are sent for histological examination. Confirmation of malignancy *must* be received before itemisation of accounts for Medicare benefits purposes.

T8.24.4 Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, items 31205 to 31240 should be used. Malignant tumours are covered by items 31255 to 31355.

T8.24.5 A practitioner providing the first treatment episode for a primary BCC/SCC must use the appropriate item from the following: 31255; 31260; 31265; 31270; 31275; 31280; 31285; or 31290.

T8.24.6 Where residual BCC/SCC remains following an initial excision of a primary lesion and the same practitioner is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31256; 31261; 31266; 31271; 31276; 31281; 31286 or 31291.

T8.24.7 Where residual BCC/SCC remains following an initial excision of a primary lesion and a practitioner other than the practitioner that performed the previous excision is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31257; 31262; 31267; 31272; 31277; 31282; 31287 or 31292.

T8.24.8 Where a BCC/SCC was removed and complete excision of the lesion was confirmed, but a BCC/SCC has recurred at the primary site, then the items providing for recurrent BCC/SCC would usually apply.

T8.24.9 A practitioner excising a recurrent BCC/SCC of the head or neck and who is a specialist in the practice of his or her specialty or a practitioner other than the practitioner who provided previous treatment (where the lesion was removed by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy) must use item 31295.

T8.24.10 A practitioner excising a recurrent BCC/SCC from an area other than the head or neck or who otherwise does not meet the criteria as described under item 31295 must use the appropriate item from the following 31258; 31263; 31268; 31273; 31278; 31283; 31288 or 31293.

T8.24.11 For the purpose of these items, the tumour/lesion size should be determined by the macroscopic measurement of the surface diameter of the tumour/lesion or, for elliptical tumours/lesions, by the average surface diameter. The relevant size of the lesion relates to that measured in situ before excision. Suture of wound following surgical excision also includes closure by tissue adhesive resin, clips or similar.

T8.24.12 Definitive surgical excision for items 31300 to 31335 is defined as “surgical removal with an adequate margin and, as a result, no further surgery is indicated at the site of the primary tumour”.

T8.24.13 It will be necessary for practitioners to retain copies of histological reports.

T8.24.14 Items 31245 and 31250 do not cover shave excision.

T8.25 Removal of Skin Lesion From Face (Items 31235-31245, 31265-31278, 31310-31320)

T8.25.1 For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

T8.26 Dissection of lymph nodes of neck (Items 31423 to 31438)

T8.26.1 For the purposes of these items, the lymph node levels referred to are as follows:-

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

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

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

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

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

T8.27 Excision of Breast Lesions, Abnormalities or Tumours - malignant or benign (Items 31500 - 31515)

T8.27.1 Therapeutic biopsy or excision of breast lesions, abnormalities or tumours under Items: 31500, 31503, 31506, 31509, 31512, 31515 either singularly or in combination should not be claimed when using the Advanced Breast Biopsy Instrumentation (ABBI) procedure, or any other large core breast biopsy device.

T8.28 Subcutaneous Mastectomy (Items 31521, 31524, 31527)

T8.28.1 When, after completing a subcutaneous mastectomy a prosthesis is inserted, benefits are payable for the latter procedure under Item 45527, the multiple operation formula applying.

T8.28.2 Claims for benefits under item 45585 are not payable in association with 31521 or 31527.

T8.29 Fine Needle Aspiration of Breast Lesion (Item 31533)

T8.29.1 An impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

T8.30. Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation (Items 31539, 31545)

T8.30.1 For the purposes of Items 31539 and 31545, surgeons performing this procedure should have evidence of appropriate training via a course approved by the Breast Section of the Royal Australasian College of Surgeons, have experience in the procedure, and Medicare Australia notified of their eligibility to perform this procedure.

T8.30.2 The ABBI procedure is contraindicated and should not be performed on the following subset of patients:

- Patients with mass, asymmetry or clustered microcalcifications that cannot be targeted using digital imaging equipment;
- Patients unable to lie prone and still for 30 to 60 minutes;
- Breasts less than 20mm in thickness when compressed;
- Women on anticoagulants;
- Lesions that are too close to the chest wall to allow cannula access;
- Patients weighing more than 135kg;
- Women with prosthetic breast implants.

T8.31 Preoperative localisation of breast lesion prior to the use of Advanced Breast Biopsy Instrumentation (Item 31542)

T8.31.1 For the purposes of item 31542, radiologists eligible to perform the procedure must have been identified by the Royal Australian and New Zealand College of Radiologists as having sufficient training and experience in this procedure, and Medicare Australia notified of their eligibility to perform this procedure.

T8.32 Per anal excision of rectal tumour using stereoscopic rectoscopy (Items 32103, 32104 and 32106)

T8.32.1 For the purposes of items 32103, 32104 and 32106, surgeons performing this procedure should be colorectal surgeons and have evidence of the appropriate training which are recognised by the Colorectal Surgical Society of Australasia.

T8.32.2 Items 32103, 32104 and 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.

T8.33 Sacral Nerve Stimulation for Faecal Incontinence (Items 32213 to 32218)

T8.33.1 Based on a review of the available evidence, the Medical Services Advisory Committee found that sacral nerve stimulation for faecal incontinence is contraindicated in all patients under 18 years of age, and in patients 18 years of age or older who:

- are medically unfit for surgery;
- are pregnant or planning pregnancy;
- have irritable bowel syndrome;
- have congenital anorectal malformations;
- have active anal abscesses or fistulas;
- have anorectal organic bowel disease – including cancer;
- have functional effects of previous pelvic irradiation;
- have congenital or acquired malformations of the sacrum; or
- have had rectal or anal surgery within the previous 12 months.

T8.34 Varicose veins, Multiple Injections of (Items 32500, 32501)

T8.34.1 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 Medicare Australia, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.34.2 In items 32500 and 32501, it is sclerosant which is being injected.

T8.34.3 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 Endovascular repair of abdominal aortic aneurysm (Items 33116 and 33119)

T8.35.1 These items were introduced into the Schedule on an interim basis via Ministerial Determination under section 3C of the Health Insurance Act, following a recommendation of the Medicare Services Advisory Committee (MSAC). Interim funding is being provided to facilitate collection of Australian evidence of the medium term safety and effectiveness of these services. An audit of these services is being conducted by the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). Continuation of funding is dependent on progress of the audit. Therefore providers of these services are strongly encouraged to take part in the audit. Further information on the review of these procedures and the audit is available from the MSAC Secretariat (see para 8.4 of the General Explanatory Notes).

T8.36 Arterial and Venous Patches (Items 33545-33551, 34815)

T8.36.1 Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

T8.36.2 Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be 34815 or 34518. If the vein is harvested for the patch through a separate incision, Item 33551 would also apply, in accordance with the multiple operation rule.

T8.36.3 If a patch graft is involved in conjunction with an operative procedure included in Items 33500 - 33542, 33803, 33806, 33815, 33833 or 34142, the patch graft would attract benefits under Item 33545 or 33548 in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item 33551 would also apply.

T8.37 Embolectomy or Thrombectomy (Item 33806)

T8.37.1 Benefit is payable once only per extremity, regardless of the number of incisions required to access the artery or bypass graft

T8.38 Carotid percutaneous transluminal angioplasty with stenting

T8.38.1 This item is introduced into the Schedule following a recommendation of the Medical Services Advisory Committee (MSAC). MSAC recommended that "CPTAS should be funded for patients who meet the criteria for CEA (carotid endarterectomy) but are unfit for open surgery (CEA)." A continuing review of the item usage will be undertaken.

T8.38.2 The indications for CEA are: >50% stenosis of carotid artery associated with stroke or transient ischaemic attack; or, >80% asymptomatic carotid stenosis. Medical comorbidities which would be considered to make patients at high risk of anaesthetic perioperative complications at open CEA are: significant coronary artery disease; severe heart failure; severe pulmonary disease; or, age greater than 80 years. Surgical conditions which would make patients unfit for open surgery are: recurrent stenosis post CEA; high cervical internal carotid lesion (above C2); low common carotid lesion below the clavicle; contralateral carotid occlusion; contralateral laryngeal nerve palsy; tracheostomy; or, prior radiation therapy of the neck or neck dissection.

T8.39 Peripheral Arterial or Venous Catheterisation (Item 35317)

T8.39.1 Item 35317 is restricted to the use of those chemotherapeutic agents other than antibiotic or antiviral agents.

T8.40 Peripheral Arterial or Venous Embolisation (Item 35321)

T8.40.1 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).

T8.41 Intravascular Brachytherapy for Coronary Artery Restenoses (Items 38321 – 38330)

T8.41.1 These items were introduced into the Schedule on an interim basis following a recommendation from the Medical Services Advisory Committee (MSAC). Interim funding is being provided for a period of 3 years, from 1 November 2003 to 31 October 2006, pending further assessment of the long-term safety, efficacy and cost-effectiveness of the procedure, and the impact of emerging technologies such as drug-eluting stents. Further information on the review of these items is available from the MSAC Secretariat (see para 8.4 of the General Explanatory Notes).

T8.42 Percutaneous Transluminal Rotational Atherectomy (Items 38309, 38312, 38315, 38318)

T8.42.1 A coronary artery lesion is considered to be complex when the lesion is a chronic total occlusion, located at an ostial site, angulated, tortuous or greater than 1cm in length. Percutaneous transluminal coronary rotational atherectomy is suitable for revascularisation of complex and heavily calcified coronary artery stenoses in patients for whom coronary artery bypass graft surgery is contraindicated.

T8.42.2 Each of the items 38309, 38312, 38315 and 38318 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

T8.43 Colposcopic Examination (Item 35614)

T8.43.1 It should be noted that colposcopic examination (screening) of women during the course of a consultation does not attract Medicare benefits under Item 35614 except in the following circumstances:- (i) where the patient has had an abnormal cervical smear; (ii) where there is a history of ingestion of oestrogen by the patient's mother during her pregnancy; or (iii) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

T8.44 Hysteroscopy (Item 35626)

T8.44.1 Hysteroscopy undertaken in the office/consulting rooms can be claimed under this item where the conditions set out in the description of the item are met.

T8.45 Curettage of Uterus under GA or Major Nerve Block (Items 35639, 35640)

T8.45.1 Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under these items but would be paid under Item 35620 where malignancy is suspected, or otherwise on an attendance basis.

T8.46 Neoplastic Changes of the Cervix (Items 35644-35648)

T8.46.1 The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

T8.47 Sterilisation of Minors - Legal Requirements (Items 35657, 35687, 35688, 35691, 37622, 37623)

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.

(ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.

(iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures.

(iv) Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973.*

T8.48 Debulking of Uterus (Item 35658)

T8.48.1 Benefits are payable under Item 35658, using the multiple operation rule, in addition to vaginal hysterectomy.

T8.49 Reversal of Sterilisation (Items 35700, 37616 and 37619)

T8.49.1 The restriction on reversal of elective sterilisation will remain if the patient is not suffering from any complications and is seeking the reversal to restore patency for the purposes of reproduction.

T8.49.2 Payment of Medicare benefits will be considered in the following circumstances:

– If the sterilisation procedure was performed for a relevant clinical reason other than elective sterilisation;

or

– If the reversal of sterilisation is required for a relevant clinical reason other than achieving conception.

T8.49.3 Claims for Medicare benefits in respect of items 35700, 37616 and 37619 should be accompanied by detailed clinical reasons for the reversal.

T8.49.4 The claim and the additional information should be lodged with Medicare, for referral to the applicable State Office of Medicare Australia, in a sealed envelope marked "Medical –In-Confidence" for consideration of the State Medical Adviser at the following address: Medicare GPO BOX 9822 in the capital city in each state.

T8.50 Nephrectomy (Items 36526 and 36527)

T8.50.1 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.

T8.51 Selective Coronary Angiography (items 38215-38246)

T8.51.1 Each item in the range 38215-38240 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

T8.51.2 Item 38243 may be billed once only immediately prior to any coronary interventional procedure, including situations where a second operator performs any coronary interventional procedure after diagnostic angiography by the first operator.

T8.51.3 Item 38246 may be billed when the same operator performs diagnostic coronary angiography and then proceeds directly with any coronary interventional procedure during the same occasion of service. Consequently, it may not be billed in conjunction with items 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243. In the event that the same operator performed any coronary interventional procedure immediately after the diagnostic procedure described by item 38231, 38237 or 38240, that item may be billed as an alternative to item 38246.

T8.51.4 Items in the range 38215 – 38246 cannot be claimed for any intravascular ultrasound (IVUS) procedure therefore Medicare Benefits are not payable for IVUS.

T8.52 Transurethral Needle Ablation (TUNA) of the Prostate

T8.52.1 Moderate to severe lower urinary tract symptoms are defined using the American Urological Association (AUA) Symptom Score or the International Prostate Symptom Score (IPSS).

T8.52.2 Patients not medically fit for transurethral resection of the prostate (TURP) can be defined as:

(i) Those patients who have a high risk of developing a serious complication from the surgery. Retrograde ejaculation is **not** considered to be a serious complication of TURP.

(ii) Those patients with a co-morbidity which may substantially increase the risk of TURP or the risk of the anaesthetic necessary for TURP.

T8.52.3 These items were introduced into the Schedule on an interim basis following a recommendation of the Medical Services Advisory Committee (MSAC). Interim funding until 1 November 2005 is being provided to facilitate collection of Australian evidence of the long term effectiveness, cost-effectiveness and safety of these services. Data collection and analysis is being conducted by the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). Continuation of funding is dependent on the progress of this data collection. Therefore providers of these services are strongly encouraged to take part in the data collection process. Further information on the review of these items and the data collection process is available from the MSAC Secretariat (see para 8.4 of the General Explanatory Notes).

T8.53 Ureteroscopy (Item 36803)

T8.53.1 Item 36803 refers to ureteroscopy of one ureter when performed for the purpose of inspection alone. It may not be used when one of the other ureteroscopy numbers (Items 36806 or 36809) or pyeloscopy numbers (Items 36652, 36654 or 36656) is used for a ureteroscopic procedure performed in the same ureter or collecting system. It may be used when inspection alone is carried out in one ureter independently from a ureteroscopic or pyeloscopic procedure in another ureter or collecting system. If Item number 36803 is used with one of the other above 5 numbers, it must be specified that item number 36803 refers to ureteroscopy performed in another ureter eg 36654 (Right side) and 36803 (Left side). 36803 may also be used in this way if there is a partial or complete duplex collecting system eg 36809 (Lower pole moiety ureter, Left side) and 36803 (Upper pole moiety ureter, Left side).

T8.53.2 Item numbers 36806 and 36809 may only be used together when 2 independent ureteroscopic procedures are performed in separate ureters. These separate ureters may be components of a complete or partial duplex system. If both these numbers are used together, the Regulations require qualification of these item numbers by the site, as is necessary with 36803 eg 36806 (Right side) and 36809 (Left side).

T8.54 Brachytherapy of the Prostate (Item 37220)

T8.54.1 Brachytherapy treatment is only recommended for patients with a gland volume of less than or equal to 40cc and who have a life expectancy of at least 10 years.

T8.54.2 An approved site is one that has been licensed by the relevant Radiation Advisory Body.

T8.55 Radical or Debulking Operation for Ovarian Tumour including Omentectomy (Item 35720)

T8.55.1 This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy benefits are payable under both item numbers with the application of the multiple operation formula.

T8.56 Cardiac Pacemaker Insertion (Items 38209, 38212, 38353, 38356)

T8.56.1 The fees for the insertion of a pacemaker (Items 38281 and 38284) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function. Accordingly, additional benefits are not payable for such routine testing under Item 38353 or 38356 (Cardiac electrophysiological studies).

T8.57 Implantable ECG Loop Recorder (Item 38285)

T8.57.1 The fee for implantation of the loop recorder (item 38285) covers the initial programming and testing of the device for satisfactory rhythm capture. Benefits are payable only once per day.

T8.57.2 The term "recurrent" refers to more than one episode of syncope, where events occur at intervals of 1 week or longer. The term "other available cardiac investigations" includes the following:

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;
- electrocardiography (ECG) (items 1170-11702);
- echocardiography (items 55113-55115);
- continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);
- up-right tilt table test (item 11724); and
- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

T8.58 Intravascular extraction of permanent pacing leads (Item 38358)

T8.58 For the purposes of Item 38358 specialists or consultant physicians claiming this item must have training recognised by the Lead Extraction Advisory Committee of the Cardiac Society of Australia and New Zealand, and the Health Insurance Commission notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

T8.59 Coronary Artery Bypass (Items 38497 – 38504)

T8.59.1 The fees for Items 38497 and 38498 include the harvesting of vein graft material. Harvesting of internal mammary artery and/or vein graft material is covered in the fees for Items 38500, 38501, 38503 and 38504. Where harvesting of an artery other than the internal mammary artery is undertaken, benefits are payable under Item 38496 on the multiple operation basis. The procedure of coronary artery bypass grafting using arterial graft is covered by Item 38500, 38501, 38503 or 38504 irrespective of the origin of the arterial graft.

T8.59.2 Items 38498, 38501 and 38504 require that either a clinical or medical perfusionist are present in the operating theatre throughout the procedure in case it is necessary to convert to an on-pump procedure and cardiopulmonary bypass is required.

T8.59.3 If it is necessary to provide cardiopulmonary bypass items 38498, 38501 and 38504 cannot be claimed. The procedure should be claimed under items 38497, 38500 or 38503 as appropriate in conjunction with the relevant cardiopulmonary bypass procedures.

T8.60 Re-operation via Median Sternotomy (Item 38640)

T8.60.1 Medicare benefits are payable for Item 38640 plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula. Benefits are not payable for Item 38640 in association with Item 38656, 38643 or 38647.

T8.61 Skull Base Surgery (Items 39640 - 39662)

T8.61.1 The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

T8.61.2 Items 39640 to 39662 cover the removal of the tumour, which would normally be performed by a neurosurgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as ENT and plastic and reconstructive surgery.

T8.62 Intradiscal Injection of Chymopapain (Item 40336)

T8.62.1 The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

T8.63 Removal of Ventilating Tube from Ear (Item 41500)

T8.63.1 Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

T8.64 Meatoplasty (Item 41515)
T8.64.1 When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

T8.65 Reconstruction of Auditory Canal (Item 41524)
T8.65.1 When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

T8.66 Removal of Nasal Polyp or Polypi (Items 41662, 41665, 41668)
T8.66.1 Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item 41662. However where the associated procedure is of lesser value than Items 41665/41668, benefit for removal of polypi would be paid under Items 41665/41668.

T8.67 Larynx, Direct Examination (Item 41846)
T8.67.1 Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

T8.68 Microlaryngoscopy (Item 41858)
T8.68.1 This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

T8.69 Corneal Incisions (Item 42672)
T8.69.1 The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

T8.70 Capsulectomy or Lensectomy (Item 42731)
T8.70.1 The following items would be regarded as intraocular operations, and should not be itemised with Item 42731:

42551 42554 42557 42560 42563 42566
42569 42698 42701 42702 42703 42704
42707 42716 42722 42725 42734 42740
42743 42746 42761 42764 42767 42815
42857

T8.70.2 This list of exclusions was developed following consultation with the Royal Australian and New Zealand College of Ophthalmologists.

T8.71 Cyclodestructive Procedures (Items 42770 and 42771)
T8.71.1 Item 42770 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period item 42771 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked ‘Medical-in-Confidence’. (See note 8.6 of the General Explanatory Notes.)

T8.72 Laser Trabeculoplasty (Items 42782, 42783)
T8.72.1 Item 42782 is restricted to a maximum of 4 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42783 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked ‘Medical-in Confidence’. (See note 8.6 of the General Explanatory Notes.)

T8.73 Laser Iridotomy (Items 42785, 42786)
T8.73.1 Item 42785 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42786 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked ‘Medical-in Confidence’. (See note 8.6 of the General Explanatory Notes.)

T8.74 Laser Capsulotomy (Items 42788, 42789)
T8.74.1 Item 42788 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42789 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked ‘Medical-in Confidence’. (See note 8.6 of the General Explanatory Notes.)

T8.75 Laser Vitreolysis or Corticolysis of lens material or Fibrinolysis (Items 42791, 42792)

T8.75.1 Item 42791 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42792 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.76 Division of Suture by Laser (Item 42794)

T8.76.1 Benefits under this item are restricted to a maximum of 2 treatments in a 2 year period. There is no provision for additional treatments in that period.

T8.77 Laser Coagulation of Corneal or Scleral Blood Vessels (Item 42797)

T8.77.1 Benefits under this item are restricted to 4 treatments in a 2 year period. There is no provision for additional treatments in that period.

T8.77.2 Benefits are not payable under Item 42797 for procedures undertaken for cosmetic purposes (see paragraph 13.1.2 of the General Explanatory Notes).

T8.78 Ophthalmic Sutures (Item 42845)

T8.78.1 This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning.

T8.79 Full Face Chemical Peel (Items 45019, 45020)

T8.79.1 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 Medicare Australia, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.80 Abrasive Therapy/Resurfacing (Items 45021 - 45026)

T8.80.1 For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

T8.80.2 Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under these items.

T8.81 Foreign Implant (Item 45051)

T8.81.1 For Medicare benefits to be payable for this item the intention of the implantation must be either to reconstruct facial or body contours which have been damaged by trauma or disease or to correct a deformity which has been pathologically caused.

T8.82 Escharotomy (Item 45054)

T8.82.1 Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

T8.83 Local Skin Flap - Definition

T8.83.1 A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

T8.83.2 By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

T8.83.3 A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Items 45200, 45203 or 45206 once only.

T8.83.4 Items where benefit for local skin flap repair (if indicated as above) is payable, include:

30023, 30180, 30186, 30269, 31200-31340, 45030, 45033, 45036-45045, 45506, 45512, 45626.

Note: This list is not all-inclusive and there are circumstances where other services might involve flap repair.

T8.83.5 The following items are examples of where local flap repair would usually not be payable. If further advice is required, Medicare Australia should be contacted.

30026-30052, 30099-30114, 30165-30177, 45520, 45522, 45524, 45563, 45587, 45632-45644, 45659, 45662, 45677-45713.

T8.84 Free grafting to burns (Items 45406 - 45418)

T8.84.1 Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

T8.85 Revision of scar (Items 45506 to 45518)

T8.85.1 For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape and facial aperture.

T8.85.2 Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital or approved day-hospital facility.

T8.85.3 Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

T8.85.4 For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31200 to 31240 should be claimed.

T8.86 Augmentation Mammaplasty (Items 45524, 45527, 45528)

T8.86.1 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. When both mastopexy for breast ptosis (items 45556, 45557 and 45558) and augmentation mammaplasty are performed on the same side, benefits are only payable for one or the other procedure, not both procedures. Benefits are not payable for augmentation mammaplasty services performed using fat transfer to the breast.

T8.87 Breast Reconstruction, Myocutaneous Flap (Item 45530)

T8.87.1 When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

T8.87.2 When a rectus abdominus flap is used, secondary repair of the muscle defect by an external oblique muscle flap would be covered under Item 45012. However, where the repair is by Teflon or similar mesh, Item 30405 should be itemised.

T8.88 Breast Ptosis (Items 45556, 45557 and 45558)

T8.88.1 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 or if augmentation mammaplasty is performed simultaneously on the same side.

T8.88.2 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 Medicare Australia, in a sealed envelope marked ‘Medical-in Confidence’. (See note 8.6 of the General Explanatory Notes.) These items are payable only once per patient.

T8.89 Nipple and/or Areola Reconstruction (Item 45545, 45546)

T8.89.1 Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

T8.89.2 Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

T8.90 Liposuction (Items 45584, 45585 and 45586)

T8.90.1 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.

T8.90.2 Where liposuction is indicated for the treatment of conditions such as pathological lipodystrophy of hips, buttocks, thighs and knees or lower legs (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 Medicare Australia, in a sealed envelope marked ‘Medical-in Confidence’. (See note 8.6 of the General Explanatory Notes.)

T8.90.3 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 Medicare Australia, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.91 Meloplasty for Correction of Facial Asymmetry (Items 45587, 45588)

T8.91.1 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.

T8.91.2 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 Medicare Australia, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.91.3 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.

T8.92 Reduction of Eyelids (Items 45617, 45620)

T8.92.1 Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits. Where there is doubt as to whether benefits would be payable, advice should be sought from a medical adviser of Medicare Australia.

T8.93 Rhinoplasty (45638, 45639)

T8.93.1 Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

T8.93.2 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.

T8.93.3 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 Medicare Australia, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.94 Contour Restoration (Item 45647)

T8.94.1 For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

T8.95 Vermilionectomy (Item 45669)

T8.95.1 Item 45669 covers treatment of the entire lip.

T8.96 Osteotomy of Jaw (Items 45720 - 45752)

T8.96.1 The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

T8.96.2 For the purposes of these items, a reference to maxilla includes the zygoma.

T8.97 Genioplasty (Items 45761)

T8.97.1 Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

T8.98 Tumour, cyst, ulcer or scar (Items 45801 – 45813)

T8.98.1 It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

T8.99 Reduction of Dislocation or Fracture

T8.99.1 Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

T8.99.2 Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

T8.99.3 Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.
T8.99.4 The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

T8.100 Lumbar Discectomy (Item 48636)
T8.100.1 Following an MSAC assessment of Intradiscal Electrothermal Annuloplasty (IDETA), it was recommended that public funding not be supported for IDETA at this time therefore medical benefits are not payable for the IDETA procedure. A restriction has been placed on the item 48636 (lumbar discectomy). This item cannot be claimed for IDETA.

T8.101 Internal Fixation (Items 48678-48690)
T8.101.1 Benefits under these items are only attracted where internal fixation is carried out in association with spinal fusion covered by Items 48642 to 48675. The multiple rule would apply in each instance.

T8.102 Wrist Surgery (Items 49200-49227)
T8.102.1 For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

T8.103 Joint or other Synovial Cavity, Aspiration of, or Injection into (Items 50124, 50125)
T8.103.1 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 Medicare Australia, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.104 Non-resectable Hepatocellular Carcinoma Destruction of by Open or Laparoscopic Radiofrequency Ablation (50952)
T8.104.1 A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

ASSISTANCE AT OPERATIONS (Group T9)

T9.1 General
T9.1.1 Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.
T9.1.2 The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.
T9.1.3 Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

T9.2 Benefits payable under Item 51300
T9.2.1 Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

T9.3 Benefits payable under item 51303
T9.3.1 Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

T9.4 Benefits Payable Under Item 51309
T9.4.1 Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a delivery involving Caesarean section.
T9.4.2 Where assistance is provided at a Caesarean section delivery and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 51306.

T9.5 Assistance at Multiple Operations

T9.5.1 Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule - Surgeon	**Multiple Operation Rule - Assistant**
Item A - $300@100%	Item A (Assist.) - $300@100%
Item B - $250@50%	Item B (No Assist.)
Item C - $200@25%	Item C (Assist.) - $200@50%
Item D - $150@25%	Item D (Assist.) - $150@25%

T9.5.2 The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

T9.6 Surgeons Operating Independently

T9.6.1 Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

T9.7 Assistance at Cataract and Intraocular Lens Surgery

T9.7.1 The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

RELATIVE VALUE GUIDE FOR ANAESTHESIA (Group T10)

T10.1 Overview of the RVG

T10.1.1 The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia (see Note T10.8). These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances (see point T10.9). These items are listed at subgroup 26.

T10.1.2 Details of the billing requirements for the RVG are available from the Medicare Australia website at:
http://www.medicareaustralia.gov.au/providers/resources/publications_guidlines/medicare/rvg_pamphlet_amended_final.pdf

T10.1.3 The RVG is based on an anaesthesia unit system reflecting the difficulty of the service and the total time taken for the service. Each unit has been assigned a dollar value.

T10.1.4 Under the RVG, the Medicare benefit for anaesthesia in connection with a procedure is comprised of up to three components:

The basic units allocated to each anaesthetic procedure, reflecting the degree of difficulty of the procedure (an item in the range 20100-21997). For example:

20702	**INITIATION AND MANAGEMENT OF ANAESTHESIA** for percutaneous liver biospy (4 basic units) Fee: $68.60 Benefit: 75% $51.45 85% $58.35

the time unit allocation reflecting the **total time** of the anaesthesia (an item in the range 23010-24136), for example;

23033	- 41 MINUTES to 45 MINUTES (3 units) Fee: $51.45 Benefit: 75%= $38.60 85% = $ 43.75

plus, where appropriate

modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020), for example

25015	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** where the patients age is less than 12 months of age or 70 years or greater (1 unit) Fee: $17.15 Benefit: 75% $12. 90 85% $14.60

T10.1.5 Each assistant at anaesthesia service in subgroup 26 has also been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers, as appropriate, to establish the fee for the assistant service. For example:

25200	**ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA** on a patient in imminent danger of death requiring continuous life saving emergency treatment , to the exclusion of all other patients Derived Fee: An amount of $85.75 (5 basic units) plus an item in the range 23010-24136) plus, where applicable, an item/s in the range 25000 – 25020

T10.1.6 As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate i.e

(a) the basic units allocated to whole body perfusion under item 22060;

22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, using heart-lung machine or equivalent (20 basic units) (See para T10.10 of explanatory notes to this Category) Fee: $343.00 Benefit: 75% = $275.25 85% = $291.55

(b) plus, the **time** unit allocation reflecting the **total time** of the perfusion (an item in the range 23010 – 24136), for example;

23033	41 MINUTES TO 45 MINUTES (3 basic units) Fee: $51.45 Benefit: 75% = $38.60 85% = $43.75

plus, where appropriate

(c) **modifying** units recognising certain added complexities in perfusion (an item/s in the range 25000 – 25020) for example

I 25015	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** - where the patient's age is up to one year or 70 years or greater (1 basic units) Fee: $17.15 Benefit: 75% = $12.9085% = $14.60

T10.2 Eligible Services

T10.2.1 With some exceptions (see note T10.13), a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. Under the Health Insurance Regulations, an "eligible" service is defined as a clinically relevant professional service (as outlined in paragraph 1.1.4 of the General Explanatory Notes of the Medicare Benefits Schedule) which is listed in the Schedule and which has been identified as attracting an anaesthetic fee**.**

T10.3 RVG Unit Values

Basic Units

T10.3.1 The RVG basic unit allocation represents the degree of difficulty of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

T10.3.2 The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- ***for anaesthesia***, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- ***for assistance at anaesthesia***, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- ***for perfusion***, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

T10.3.3 For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).
T10.3.4 For statistical purposes, the first 2 hours of time after the first 15 minutes is represented in the Medicare Benefits Schedule by item numbers in 5 minute increments.

For example:

	ANAESTHESIA, ASSISTANCE AT ANAESTHESIA OR PERFUSION TIME - for anaesthesia in connection with an eligible medical service or a dental service or assistance at anaesthesia in connection with an eligible medical service or for perfusion in connection with an eligible medical service		
23010	- 15 MINUTES OR LESS (1 unit) Fee: $17.15	Benefit: 75%= $12.90	Benefit: 85% = $14.60
23021	- 16 MINUTES TO 20 MINUTES (2 units) Fee: $34.30	Benefit: 75%= $25.75	Benefit: 85% = $29.20
23022	- 21MINUTES to 25 MINUTES (2 units) Fee: $34.30	Benefit: 75%= $25.75	Benefit: 85% = $29.20
23023	- 26 MINUTES to 30 MINUTES (2 units) Fee: $34.30	Benefit: 75%= $25.70	Benefit: 85% = $29.15
23031	- 31 MINUTES to 35 MINUTES (3 units) Fee: $51.45	Benefit: 75%= $38.60	Benefit: 85% = $43.75
23032	- 36 MINUTES to 40 MINUTES (3 units) Fee: $51.45	Benefit: 75%= $38.60	Benefit: 85% = $43.75
23033	- 41 MINUTES to 45 MINUTES (3 units) Fee: $51.45	Benefit: 75%= $38.60	Benefit: 85% = $43.75

T10.3.5 For services lasting between 15 minutes and two hours, the appropriate 5 minute item number should be included on accounts.

Modifying Units (25000 – 25050)
T10.3.6 Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

- **ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000)**. This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

  Some examples of clinical situations to which ASA 3 would apply are:
  - a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;
  - a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;
  - a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or
  - a patient who has renal failure requiring regular dialysis.

- **ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005)**. This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

  ASA physical status indicator 4 would be characterised by the following clinical examples:
  - a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;

- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or
- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:-
  - severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or
  - severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

- **ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010)**. This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

  The following are some examples that would equate to ASA physical status indicator 5
  - a burst abdominal aneurysm with profound shock;
  - major cerebral trauma with increasing intracranial pressure; or
  - massive pulmonary embolus.

NOTE: It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2. Some examples of ASA 2 would include:

- a patient with controlled hypertension which has no affect on the patient's normal lifestyle;
- a patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- a patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle."

- *Where the patient is less than 12 months or age or 70 years or greater (item 25015).*
- *For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).*
- *For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).*
- *For a perfusion service in association with *after hours emergency surgery (item 25050).*

*** NOTE: It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.**

T10.3.7 **It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.**

Definition of Emergency
T10.3.8 For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as being where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours
T10.3.9 For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies see point T10.4.2.

T10.4 Deriving the Schedule Fee under the RVG

T10.4.1 The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule was derived by applying the unit value to the total number of anaesthesia units for each component . For example:

ITEM	**DESCRIPTION**		**SCHEDULE FEE**
17603	Pre-anaesthesia Consultation		$ 37.15
RVG	**Anaesthesia Service**	**Units**	**SCHEDULE FEE (Units x $ 17.15)**
20840	Anaesthesia for resection of perforated bowel	6	$ 102.90
23190	Time – 4 hours 40 minutes	24	$411.60
25000	Modifier - Physical status	1	$ 17.15
22012	Central Venous Pressure Monitoring	3	$51.45

T10.4.2 After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	**DESCRIPTION**	**UNITS**	**SCHEDULE FEE (Units x $17.15)**
20840	Anaesthesia for resection of perforated bowel	6	$ 102.90
23190	Time – 4 hours 40 minutes	24	$411.60
25000	Modifier - Physical status	1	$ 17.15
22012	Central Venous Pressure Monitoring	3	$51.45
	TOTAL UNITS	34	Schedule fee = **$583.10**
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee $ 583.10 x 50% **=291.55**

T10.4.3 Definition of Radical Surgery

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems.

T10.4.4 Multiple Anaesthesia Services

T10.4.3.1 Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	**DESCRIPTION**	**UNITS**	**SCHEDULE FEE**
20790	Anaesthesia for Cholecystectomy	8	$ 137.20
20752	Incisional Hernia	6	$ 0.00
23111	Time – 2hrs 30mins	11	$188.65
25015	Physical Status – Over 70	1	$ 17.15

T10.4.5 Prolonged Anaesthesia

T10.4.4.1 Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

T10.5 Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation)

T10.5.1 Medicare benefits for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists (ANZCA).

Staffing

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;
- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;
- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and
- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

Facilities

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;
- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;
- Appropriate drugs for cardiopulmonary resuscitation;
- A pulse oximeter; and
- Ready access to a defibrillator.

T10.5.2 These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

T10.6 Account Requirements

T10.6.1 Before a benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out at paragraph 7.1 of the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:

the anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. As well, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.

the assistant anaesthetist's account must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.

The perfusionist's account must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

T10.7 General Information

T10.7.1 The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

T10.7.2 Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

T10.7.3 Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.9).

It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

T10.7.4 The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 24 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.9)

T10.7.5 Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph

T10.4. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.
T10.7.6 When a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by him/her, then such a block will attract benefit under the appropriate item in Group T7.
T10.7.7 It should be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.
T10.7.8 It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.
T10.7.9 The administration of epidural anaesthesia during labour is covered by Item 18216 or 18219 in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

T10.8 Additional Services performed in connection with Anaesthesia– Subgroup 19
T10.8.1 Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as pulmonary artery pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).
T10.8.2 These items (with the exception of peri-operative nerve blocks (22030-22050)) and perfusion services (22055–22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.
T10.8.3 Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

T10.9 Assistance in the Administration of Anaesthesia (Items 25200 and 25205)
T10.9.1 The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.
T10.9.2 Assistance at anaesthesia in connection with emergency treatment (Item 25200)
Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.
T10.9.3 Assistance in the administration of elective anaesthesia (Item 25205)
T10.9.4 A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.
T10.9.5 For the purposes of Item 25205, a “complex paediatric case” involves one or more of the following:-
(i) the need for invasive monitoring (intravascular or transoesophageal); or
(ii) organ transplantation; or
(iii) craniofacial surgery; or
(iv) major tumour resection; or
(iv) separation of conjoint twins.

T10.10 Perfusion Services (Items 22055-22075)
T10.10.1 Perfusion services covered by items 22055-22075 have been included in the RVG format.
T10.10.2 The “Time” component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.
T10.10.3 Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated medical service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10. The service must be performed by a medical practitioner in order to attract Medicare benefits. The “on behalf of” provisions do not apply.
T10.10.4 Medicare benefit is payable where the perfusionist provides a clinically necessary service/s from Group T10, Subgroup 19 in addition to the perfusion service.

T10.11 Anaesthesia as a therapeutic procedure (Item 21965)
T10.11.1 Claims under this item should be submitted to Medicare for approval of benefits and should contain full clinical details of the service. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked ‘Medical-in Confidence’. (See note 8.6 of the General Explanatory Notes.)

T10.12 Discontinued Surgery (Item 21990)
T10.12.1 Claims for benefits under Item 21990 should be submitted to Medicare for approval of benefits and should include full details of the circumstances of the operation, including details of the surgery which had been proposed and the reasons for the operation being discontinued.

T10.13 Anaesthesia in connection with a procedure not identified as attracting a Medicare benefit for anaesthesia (Item 21997)
T10.13.1 Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T10.14 Anaesthesia in connection with a dental service (Items 22900 and 22905)
T10.14.1 Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an "eligible" service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

T10.15 Anaesthesia in connection with cleft lip and cleft palate repair (Items 20102 and 20172)
T10.15.1 Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

T10.16 Anaesthesia in connection with an Oral and MaxillofaciaI service (Category 4 of the Medicare Benefits Schedule)
T10.16.1 Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

T10.17 Intra-operative blocks for post operative pain (Items 22031 to 22050)
T10.17.1 Benefits are only payable for intra-operative nerve blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22050.

T10.18 Anaesthesia in connection with extensive surgery on facial bones(20192)
The term "extensive" in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

T10.19 Intrathecal or Epidural injection for Control of Post-operative Pain - Initial ((Item 22031)
T10.19.1 Benefits are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Benefit is not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, benefit would be payable under items 18222 or 18225.

T10.20 Intrathecal or Epidural Injection for Control of Post-operative Pain - Subsequent (Item - 22036)
T10.20.1 Benefits are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Benefits are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

T10.21 Regional or Field Nerve Blocks for Post-operative Pain (Items 22040 - 22050)
T10.21.1 Benefits are payable under Items 22040 to 22050 in addition to the general anaesthesia for the related procedure.

T10.22 Anaesthesia for radical procedures on the chest wall (Item 20474)
T10.22.1 Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

T10.23 Anaesthesia for extensive spine or spinal cord procedures (Item 20670)
T10.23.1 This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

T10.24 Anaesthesia for femoral artery embolectomy (Item 21274)

T10.24.1 Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

T10.25 Anaesthesia for cardiac catheterisation (Item 21941)

T10.25.1 Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

T10.26 Anaesthesia for 2 dimensional real time transoesophageal echocardiography (Item 21936)

T10.26.1 Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

T10.27 Anaesthesia for services on the upper and lower abdomen (subgroups 6 and7)

T10.27.1 Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

T11 Botulinum Toxin (Items 18350 - 18371)

T11.1 The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently two botulinum toxin agents with TGA registration (Botox and Dysport). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

T11.2 The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

T11.3 Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is registered by the Health Insurance Commission to participate in the arrangements under Section 100 of the *National Health Act 1953* relating to the use and supply of Botulinum Toxin.

T11.4 Items 18354, 18356 and 18358 for the treatment of equinus, equinovarus or equinovalgus are limited to a maximum of 4 injections per patient on any one day (2 per limb). Accounts should be annotated with the limb which has been treated.

T11.5 Botulinum Toxin, which is not supplied and administered in accordance with the arrangements under Section 100 of the National Health Act 1953, is not free of charge to patients. Where a charge is made for the Botulinum Toxin administered, it must be separately listed on the account and not billed to Medicare.

	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES
	SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY
13020	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance *(See para T1.1 of explanatory notes to this Category)* **Fee:** $223.95 **Benefit:** 75% = $168.00 85% = $190.40
13025	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour) *(See para T1.1 of explanatory notes to this Category)* **Fee:** $100.15 **Benefit:** 75% = $75.15 85% = $85.15
13030	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour) *(See para T1.1 of explanatory notes to this Category)* **Fee:** $141.45 **Benefit:** 75% = $106.10 85% = $120.25
	SUBGROUP 2 - DIALYSIS
13100	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $118.25 **Benefit:** 75% = $88.70 85% = $100.55
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $61.60 **Benefit:** 75% = $46.20 85% = $52.40
H 13104	PLANNING AND MANAGEMENT OF HOME DIALYSIS (either haemodialysis or peritoneal dialysis), by a consultant physician in the practice of his or her specialty of renal medicine, for a patient with end-stage renal disease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims per year *(See para T1.3 of explanatory notes to this Category)* **Fee:** $128.05 **Benefit:** 85% = $108.85
13106	DECLOTTING OF AN ARTERIOVENOUS SHUNT **Fee:** $105.05 **Benefit:** 75% = $78.80 85% = $89.30
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.) **Fee:** $197.05 **Benefit:** 75% = $147.80 85% = $167.50
13110	TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes.) **Fee:** $197.75 **Benefit:** 75% = $148.35 85% = $168.10
13112	PERITONEAL DIALYSIS, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.) **Fee:** $118.25 **Benefit:** 75% = $88.70 85% = $100.55
	SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES
13200	ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures) involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13203, 13206 or 13218 applies - being services rendered during 1 treatment cycle, if the duration of the treatment cycle is at least 9 days *(See para T1.4 of explanatory notes to this Category)* **Fee:** $1,730.30 **Benefit:** 75% = $1,297.75 85% = $1,668.80

13203	OVULATION MONITORING SERVICES, for superovulated treatment cycles of less than 9 days duration and artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which item 13200, 13206, 13212, 13215 or 13218 applies *(See para T1.4 of explanatory notes to this Category)* **Fee:** $432.60	**Benefit:** 75% = $324.45	85% = $371.10
13206	ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures), using unstimulated ovulation or ovulation stimulated only by clomiphene citrate, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies *(See para T1.4 of explanatory notes to this Category)* **Fee:** $741.50	**Benefit:** 75% = $556.15	85% = $680.00
13209	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies including in vitro fertilisation, gamete intrafallopian transfer and similar procedures, or for artificial insemination payable once only during 1 treatment cycle *(See para T1.4 of explanatory notes to this Category)* **Fee:** $74.05	**Benefit:** 75% = $55.55	85% = $62.95
13212	OOCYTE RETRIEVAL by any means including laparoscopy or ultrasoundguided ova flushing, for the purposes of assisted reproductive technologies including in vitro fertilisation, gamete intra-fallopian transfer or similar procedures - only if rendered in conjunction with a service to which item 13200 or 13206 applies (Anaes.) *(See para T1.4 of explanatory notes to this Category)* **Fee:** $315.20	**Benefit:** 75% = $236.40	85% = $267.95
13215	TRANSFER of EMBRYOS or both ova and sperm to the female reproductive system, by any means but excluding artificial insemination or the transfer of frozen or donated embryos - only if rendered in conjunction with a service to which item 13200 or 13206 applies, being services rendered in 1 treatment cycle (Anaes.) *(See para T1.4 of explanatory notes to this Category)* **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
13218	PREPARATION AND TRANSFER of frozen or donated embryos or both ova and sperm, to the female reproductive system, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13203, 13206, 13212 or 13215 applies (Anaes.) *(See para T1.4 of explanatory notes to this Category)* **Fee:** $741.50	**Benefit:** 75% = $556.15	85% = $680.00
13221	PREPARATION OF SEMEN for the purposes of assisted reproductive technologies or for artificial insemination *(See para T1.4 of explanatory notes to this Category)* **Fee:** $45.15	**Benefit:** 75% = $33.90	85% = $38.40
13290	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required **Fee:** $176.80	**Benefit:** 75% = $132.60	85% = $150.30
13292	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital or approved day-hospital facility (Anaes.) **Fee:** $353.70	**Benefit:** 75% = $265.30	85% = $300.65
	SUBGROUP 4 - PAEDIATRIC & NEONATAL		
13300	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate **Fee:** $49.30	**Benefit:** 75% = $37.00	85% = $41.95
13303	UMBILICAL ARTERY CATHETERISATION with or without infusion **Fee:** $73.05	**Benefit:** 75% = $54.80	85% = $62.10
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor **Fee:** $289.10	**Benefit:** 75% = $216.85	85% = $245.75
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected **Fee:** $246.50	**Benefit:** 75% = $184.90	85% = $209.55

13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS **Fee:** $24.60 **Benefit:** 75% = $18.45 85% = $20.95
13318	CENTRAL VEIN CATHETERISATION (via jugular or subclavian vein) - by open exposure in a person under 12 years of age (Anaes.) **Fee:** $196.85 **Benefit:** 75% = $147.65 85% = $167.35
13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.) **Fee:** $196.85 **Benefit:** 75% = $147.65 85% = $167.35
	SUBGROUP 5 - CARDIOVASCULAR
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.) **Fee:** $83.80 **Benefit:** 75% = $62.85 85% = $71.25
	SUBGROUP 6 - GASTROENTEROLOGY
13500	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant IN THE ABSENCE OF GASTROINTESTINAL HAEMORRHAGE **Fee:** $156.05 **Benefit:** 75% = $117.05 85% = $132.65
13503	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant FOR UPPER GASTROINTESTINAL HAEMORRHAGE **Fee:** $312.15 **Benefit:** 75% = $234.15 85% = $265.35
13506	GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices **Fee:** $159.65 **Benefit:** 75% = $119.75 85% = $135.75
	SUBGROUP 8 - HAEMATOLOGY
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) **Fee:** $288.45 **Benefit:** 75% = $216.35 85% = $245.20
13703	ADMINISTRATION OF BLOOD, including collection from donor **Fee:** $103.40 **Benefit:** 75% = $77.55 85% = $87.90
13706	ADMINISTRATION OF BLOOD or bone marrow already collected *(See para T1.5 of explanatory notes to this Category)* **Fee:** $72.20 **Benefit:** 75% = $54.15 85% = $61.40
13709	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation *(See para T1.6 of explanatory notes to this Category)* **Fee:** $41.90 **Benefit:** 75% = $31.45 85% = $35.65
13750	THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies -payable once per day **Fee:** $118.25 **Benefit:** 75% = $88.70 85% = $100.55
13755	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermitten flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day **Fee:** $118.25 **Benefit:** 75% = $88.70 85% = $100.55
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda **Fee:** $63.15 **Benefit:** 75% = $47.40 85% = $53.70

13760	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for: . chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or . acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogenic bone marrow transplant; or . multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or . small round cell sarcomas; or . primitive neuroectodermal tumour; or . germ cell tumours which have relapsed following, or are refractory to, chemotherapy; . germ cell tumours which have had an incomplete response to first line therapy. - performed under the supervision of a consultant physician - each day. **Fee:** $660.05 **Benefit:** 75% = $495.05 85% = $598.55
	SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
13815	CENTRAL VEIN CATHETERISATION (via jugular, subclavian or femoral vein) by percutaneous or open exposure not being a service to which item 13318 applies (Anaes.) **Fee:** $73.80 **Benefit:** 75% = $55.35 85% = $62.75
13818	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) *(See para T1.8 of explanatory notes to this Category)* **Fee:** $98.45 **Benefit:** 75% = $73.85 85% = $83.70
13830	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day **Fee:** $65.25 **Benefit:** 75% = $48.95 85% = $55.50
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
13842	INTRAARTERIAL CANNULATION for the purpose of taking multiple arterial blood samples for blood gas analysis *(See para T1.8 of explanatory notes to this Category)* **Fee:** $59.95 **Benefit:** 75% = $45.00 85% = $51.00
H 13847	COUNTERPULSATION BY INTRAAORTIC BALLOON management on the first day including initial and subsequent consultations and monitoring of parameters (Anaes.) *(See para T1.8 of explanatory notes to this Category)* **Fee:** $135.10 **Benefit:** 75% = $101.35 85% = $114.85
13848	COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day subsequent to the first, including associated consultations and monitoring of parameters **Fee:** $113.40 **Benefit:** 75% = $85.05 85% = $96.40
13851	CIRCULATORY SUPPORT DEVICE, management of, on first day **Fee:** $427.25 **Benefit:** 75% = $320.45 85% = $365.75
13854	CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first **Fee:** $99.35 **Benefit:** 75% = $74.55 85% = $84.45
I 13857	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit *(See para T1.8 of explanatory notes to this Category)* **Fee:** $126.70 **Benefit:** 75% = $95.05 85% = $107.70

	SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
	(Note: See para T1.7 of Explanatory Notes to this Category for definition of an Intensive Care Unit)
I + 13870	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day *(See para T1.9 of explanatory notes to this Category)* **Fee:** $313.40 **Benefit:** 75% = $235.05 85% = $266.40
I + 13873	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day *(See para T1.9 of explanatory notes to this Category)* **Fee:** $232.50 **Benefit:** 75% = $174.40 85% = $197.65
I + 13876	CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - each day of monitoring for each type of pressure up to a maximum of 4 pressures *(See para T1.9 of explanatory notes to this Category)* **Fee:** $66.50 **Benefit:** 75% = $49.90 85% = $56.55
H 13881	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION, in an Intensive Care Unit, not in association with any anaesthetic service, by a specialist or consultant physician for the purpose of subsequent ventilatory support *(See para T1.9 of explanatory notes to this Category)* **Fee:** $126.70 **Benefit:** 75% = $95.05 85% = $107.70
I + 13882	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day *(See para T1.9 of explanatory notes to this Category)* **Fee:** $99.75 **Benefit:** 75% = $74.85 85% = $84.80
I + 13885	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on the first day *(See para T1.9 of explanatory notes to this Category)* **Fee:** $133.00 **Benefit:** 75% = $99.75 85% = $113.05
I + 13888	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on each day subsequent to the first day *(See para T1.9 of explanatory notes to this Category)* **Fee:** $66.50 **Benefit:** 75% = $49.90 85% = $56.55
	SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES
13915	CYTOTOXIC CHEMOTHERAPY, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin **Fee:** $56.30 **Benefit:** 75% = $42.25 85% = $47.90
13918	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $84.70 **Benefit:** 75% = $63.55 85% = $72.00
13921	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment **Fee:** $95.90 **Benefit:** 75% = $71.95 85% = $81.55
13924	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05

13927	CYTOTOXIC CHEMOTHERAPY, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hours duration - payable once only on the same day **Fee:** $73.05	**Benefit:** 75% = $54.80	85% = $62.10
13930	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $101.95	**Benefit:** 75% = $76.50	85% = $86.70
13933	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment **Fee:** $113.10	**Benefit:** 75% = $84.85	85% = $96.15
13936	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $73.70	**Benefit:** 75% = $55.30	85% = $62.65
13939	IMPLANTED PUMP OR RESERVOIR, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies *(See para T1.10 of explanatory notes to this Category)* **Fee:** $84.70	**Benefit:** 75% = $63.55	85% = $72.00
13942	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies *(See para T1.10 of explanatory notes to this Category)* **Fee:** $56.50	**Benefit:** 75% = $42.40	85% = $48.05
13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of **Fee:** $45.45	**Benefit:** 75% = $34.10	85% = $38.65
13948	CYTOTOXIC AGENT, instillation of, into a body cavity **Fee:** $56.50	**Benefit:** 75% = $42.40	85% = $48.05
	SUBGROUP 12 - DERMATOLOGY		
14050	PUVA THERAPY or UVB THERAPY administered in whole body cabinet, not being a service associated with a service to which item 14053 applies including associated consultations other than an initial consultation *(See para T1.11 of explanatory notes to this Category)* **Fee:** $45.65	**Benefit:** 75% = $34.25	85% = $38.85
14053	PUVA THERAPY or UVB THERAPY administered to localised body areas in hand and foot cabinet not being a service associated with a service to which item 14050 applies including associated consultations other than an initial consultation *(See para T1.11 of explanatory notes to this Category)* **Fee:** $45.65	**Benefit:** 75% = $34.25	85% = $38.85
14100	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of vascular lesions of the head or neck where abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period (Anaes.) **Fee:** $132.00	**Benefit:** 75% = $99.00	85% = $112.20
14106	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), where the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment up to 50cm^2 (Anaes.) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $132.00	**Benefit:** 75% = $99.00	85% = $112.20
14109	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 50cm^2 and up to 100cm^2 (Anaes.) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $162.10	**Benefit:** 75% = $121.60	85% = $137.80

MISCELLANEOUS				OTHER
14112	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 100cm^2 and up to 150cm^2 (Anaes.) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $191.95	**Benefit:** 75% = $144.00	85% = $163.20	
14115	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 150cm^2 and up to 250cm^2 (Anaes.) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $221.95	**Benefit:** 75% = $166.50	85% = $188.70	
14118	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 250cm^2 (Anaes.) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $282.00	**Benefit:** 75% = $211.50	85% = $239.70	
14124	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of haemangiomas of infancy, including any associated consultation - ***where a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes.) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $132.00	**Benefit:** 75% = $99.00	85% = $112.20	
	SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES			
14200	GASTRIC LAVAGE in the treatment of ingested poison **Fee:** $51.80	**Benefit:** 75% = $38.85	85% = $44.05	
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.) **Fee:** $44.25	**Benefit:** 75% = $33.20	85% = $37.65	
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula **Fee:** $30.80	**Benefit:** 75% = $23.10	85% = $26.20	
14209	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent **Fee:** $76.80	**Benefit:** 75% = $57.60	85% = $65.30	
14212	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.) **Fee:** $160.40	**Benefit:** 75% = $120.30	85% = $136.35	
14215	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, accessing of to add or remove fluid **Fee:** $84.70	**Benefit:** 75% = $63.55	85% = $72.00	
14218	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain **Fee:** $84.70	**Benefit:** 75% = $63.55	85% = $72.00	
14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies **Fee:** $45.45	**Benefit:** 75% = $34.10	85% = $38.65	
14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.) **Fee:** $60.90	**Benefit:** 75% = $45.70	85% = $51.80	

	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 1 - SUPERFICIAL
15000	*(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10)* RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given - 1 field **Fee:** $36.85 **Benefit:** 75% = $27.65 85% = $31.35
15003	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15000 plus for each field in excess of 1, an amount of $14.80
15006	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field **Fee:** $81.70 **Benefit:** 75% = $61.30 85% = $69.45
15009	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15006 plus for each field in excess of 1, an amount of $16.05
15012	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye **Fee:** $46.25 **Benefit:** 75% = $34.70 85% = $39.35
	SUBGROUP 2 - ORTHOVOLTAGE
15100	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field **Fee:** $41.30 **Benefit:** 75% = $31.00 85% = $35.15
15103	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15100 plus for each field in excess of 1, an amount of $16.30
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field **Fee:** $48.75 **Benefit:** 75% = $36.60 85% = $41.45
15109	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15106 plus for each field in excess of 1, an amount of $19.65
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
15115	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15112 plus for each field in excess of 1, an amount of $40.95
	SUBGROUP 3 - MEGAVOLTAGE
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
15214	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15211 plus for each field in excess of 1, an amount of $27.60
15215	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
15218	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95

15221	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
15224	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221 **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
15227	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
15230	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15215 plus for each field in excess of 1, an amount of $32.80
15233	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15218 plus for each field in excess of 1, an amount of $32.80
15236	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15221 plus for each field in excess of 1, an amount of $32.80
15239	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15230, 15233 or 15236 **Derived Fee:** The fee for item 15224 plus for each field in excess of 1, an amount of $32.80
15242	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15227 plus for each field in excess of 1, an amount of $32.80
15245	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
15248	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
15251	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
15254	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251 **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
15257	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
15260	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15245 plus for each field in excess of 1, an amount of $32.80

15263	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15248 plus for each field in excess of 1, an amount of $32.80
15266	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15251 plus for each field in excess of 1, an amount of $32.80
15269	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266 **Derived Fee:** The fee for item 15254 plus for each field in excess of 1, an amount of $32.80
15272	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15257 plus for each field in excess of 1, an amount of $32.80
	SUBGROUP 4 - BRACHYTHERAPY
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $309.00 **Benefit:** 75% = $231.75 85% = $262.65
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $309.00 **Benefit:** 75% = $231.75 85% = $262.65
15307	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $585.80 **Benefit:** 75% = $439.35 85% = $524.30
15308	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $585.80 **Benefit:** 75% = $439.35 85% = $524.30
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $288.40 **Benefit:** 75% = $216.30 85% = $245.15
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $286.30 **Benefit:** 75% = $214.75 85% = $243.40
15315	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $566.20 **Benefit:** 75% = $424.65 85% = $504.70
15316	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $566.20 **Benefit:** 75% = $424.65 85% = $504.70
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
15323	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $624.85 **Benefit:** 75% = $468.65 85% = $563.35

15324	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $624.85 **Benefit:** 75% = $468.65 85% = $563.35
15327	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $679.80 **Benefit:** 75% = $509.85 85% = $618.30
15328	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $679.80 **Benefit:** 75% = $509.85 85% = $618.30
15331	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $645.45 **Benefit:** 75% = $484.10 85% = $583.95
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $645.45 **Benefit:** 75% = $484.10 85% = $583.95
15335	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $585.80 **Benefit:** 75% = $439.35 85% = $524.30
15336	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $585.80 **Benefit:** 75% = $439.35 85% = $524.30
I 15338	PROSTATE, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 6 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed at an approved site in association with a urologist. *(See para T2.3 of explanatory notes to this Category)* **Fee:** $809.70 **Benefit:** 75% = $607.30 85% = $748.20
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) **Fee:** $65.95 **Benefit:** 75% = $49.50 85% = $56.10
15342	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of greater than 115 days, to treat intracavity, intraoral or intranasal site **Fee:** $164.70 **Benefit:** 75% = $123.55 85% = $140.00
15345	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites **Fee:** $439.50 **Benefit:** 75% = $329.65 85% = $378.00
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance **Fee:** $50.55 **Benefit:** 75% = $37.95 85% = $43.00
15351	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface **Fee:** $100.95 **Benefit:** 75% = $75.75 85% = $85.85
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
15357	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 each attendance **Fee:** $34.60 **Benefit:** 75% = $25.95 85% = $29.45

I 15360	CATHETER BASED INTRAVASCULAR BRACHYTHERAPY for the treatment of in-stent restenoses of 1 coronary artery, administration of radioactive sealed sources having a half life of less than 115 days using automated intravascular brachytherapy systems approved by the Therapeutic Goods Administration. The procedure must be performed by a radiation oncologist in association with a cardiologist and be associated with a service to which item 38321, 38324, 38327 or 38330 applies. *(See para T2.4 of explanatory notes to this Category)* **Fee:** $312.45 **Benefit:** 75% = $234.35 85% = $265.60
I 15363	CATHETER BASED INTRAVASCULAR BRACHYTHERAPY for the treatment of in-stent restenoses of 1 coronary artery, administration of radioactive sealed sources having a half life of greater than 115 days using automated intravascular brachytherapy systems approved by the Therapeutic Goods Administration. The procedure must be performed by a radiation oncologist in association with a cardiologist and be associated with a service to which item 38321, 38324, 38327 or 38330 applies. *(See para T2.4 of explanatory notes to this Category)* **Fee:** $312.45 **Benefit:** 75% = $234.35 85% = $265.60
	SUBGROUP 5 - COMPUTERISED PLANNING
15500	**RADIOTHERAPY PLANNING** RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $210.05 **Benefit:** 75% = $157.55 85% = $178.55
15503	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $269.70 **Benefit:** 75% = $202.30 85% = $229.25
15506	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15515 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $402.70 **Benefit:** 75% = $302.05 85% = $342.30
15509	RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $182.05 **Benefit:** 75% = $136.55 85% = $154.75
15512	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $234.65 **Benefit:** 75% = $176.00 85% = $199.50
15513	RADIATION SOURCE LOCALISATION using a simulator or x-ray machine or CT of a single area, where views in more than 1 plane are required, for brachytherapy treatment planning for I125 seed implantation of localised prostate cancer, in association with item 15338 **Fee:** $265.40 **Benefit:** 75% = $199.05 85% = $225.60
15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $339.65 **Benefit:** 75% = $254.75 85% = $288.75
15518	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.2 of explanatory notes to this Category)* **Fee:** $66.60 **Benefit:** 75% = $49.95 85% = $56.65
15521	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.2 of explanatory notes to this Category)* **Fee:** $294.15 **Benefit:** 75% = $220.65 85% = $250.05

	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields *(See para T2.2 of explanatory notes to this Category)*		
15524	**Fee:** $551.55	**Benefit:** 75% = $413.70	85% = $490.05
	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.2 of explanatory notes to this Category)*		
15527	**Fee:** $68.30	**Benefit:** 75% = $51.25	85% = $58.10
	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.2 of explanatory notes to this Category)*		
15530	**Fee:** $304.75	**Benefit:** 75% = $228.60	85% = $259.05
	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields *(See para T2.2 of explanatory notes to this Category)*		
15533	**Fee:** $577.85	**Benefit:** 75% = $433.40	85% = $516.35
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry *(See para T2.2 of explanatory notes to this Category)*		
15536	**Fee:** $230.95	**Benefit:** 75% = $173.25	85% = $196.35
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338		
15539	**Fee:** $542.90	**Benefit:** 75% = $407.20	85% = $481.40
	CATHETER BASED INTRAVASCULAR BRACHYTHERAPY PLANNING, computerised radiation dosimetry. The procedure must be performed by a radiation oncologist in association with a cardiologist and be associated with a service to which item 38321, 38324, 38327 or 38330 applies. *(See para T2.4 of explanatory notes to this Category)*		
I 15541	**Fee:** $230.95	**Benefit:** 75% = $173.25	85% = $196.35
	SUBGROUP 6 - STEREOTACTIC RADIOSURGERY		
	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment		
15600	**Fee:** $1,473.30	**Benefit:** 75% = $1,105.00	85% = $1,411.80

	GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE
16003	INTRACAVITARY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis and not being a service associated with selective internal radiation therapy (Anaes.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $563.05 **Benefit:** 75% = $422.30 85% = $501.55
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique **Fee:** $432.65 **Benefit:** 75% = $324.50 85% = $371.15
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique **Fee:** $295.25 **Benefit:** 75% = $221.45 85% = $251.00
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32 **Fee:** $255.45 **Benefit:** 75% = $191.60 85% = $217.15
16015	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either: (i) the disease is poorly controlled by conventional radiotherapy; or (ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain **Fee:** $3,536.05 **Benefit:** 75% = $2,652.05 85% = $3,474.55
16018	ADMINISTRATION OF ^{153} SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) from either:- (i) carcinoma of the prostate, where hormonal therapy has failed; or (ii) carcinoma of the breast, where both hormonal therapy and chemotherapy have failed; and either:- (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain **Fee:** $2,113.80 **Benefit:** 75% = $1,585.35 85% = $2,052.30

GROUP T4 - OBSTETRICS

ANTENATAL CARE

	ANTENATAL ATTENDANCE *(See para T4.1 of explanatory notes to this Category)*		
16500	**Fee:** $31.45	**Benefit:** 75% = $23.60	85% = $26.75
	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy *(See para T4.2 of explanatory notes to this Category)*		
16501	**Fee:** $121.65	**Benefit:** 75% = $91.25	85% = $103.45
	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day		
16502	**Fee:** $31.45	**Benefit:** 75% = $23.60	85% = $26.75
	TREATMENT OF HABITUAL MISCARRIAGE by injection of hormones each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance		
16504	**Fee:** $31.45	**Benefit:** 75% = $23.60	85% = $26.75
	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance		
16505	**Fee:** $31.45	**Benefit:** 75% = $23.60	85% = $26.75
	PREGNANCY COMPLICATED BY acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day		
16508	**Fee:** $31.45	**Benefit:** 75% = $23.60	85% = $26.75
	PREECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of each attendance that is not a routine antenatal attendance		
16509	**Fee:** $31.45	**Benefit:** 75% = $23.60	85% = $26.75
	CERVIX, purse string ligation of (Anaes.)		
16511	**Fee:** $190.35	**Benefit:** 75% = $142.80	85% = $161.80
	CERVIX, removal of purse string ligature of (Anaes.)		
16512	**Fee:** $54.95	**Benefit:** 75% = $41.25	85% = $46.75
	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)		
16514	**Fee:** $31.75	**Benefit:** 75% = $23.85	85% = $27.00

MANAGEMENT OF LABOUR AND DELIVERY

	MANAGEMENT OF VAGINAL DELIVERY as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.) *(See para T4.3 of explanatory notes to this Category)*		
16515	**Fee:** $300.00	**Benefit:** 75% = $225.00	85% = $255.00
	MANAGEMENT OF LABOUR, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.) *(See para T4.3 of explanatory notes to this Category)*		
16518	**Fee:** $300.00	**Benefit:** 75% = $225.00	85% = $255.00
	MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.) *(See para T4.3 of explanatory notes to this Category)*		
16519	**Fee:** $461.95	**Benefit:** 75% = $346.50	85% = $400.45

	CAESAREAN SECTION and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.) *(See para T4.4 of explanatory notes to this Category)*		
16520	**Fee:** $539.90	**Benefit:** 75% = $404.95	85% = $478.40
	MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days: - multiple pregnancy; - recurrent antepartum haemorrhage from 20 weeks gestation; - grades 2, 3 or 4 placenta praevia; - baby with a birth weight less than or equal to 2500gm; - preexisting diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood; - glucose monitoring; - trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; - preexisting hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mmHg associated with at least 1+ proteinuria on urinalysis; - prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; - fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; OR - conditions that pose a significant risk of maternal death. (Anaes.) *(See para T4.5 of explanatory notes to this Category)*		
16522	**Fee:** $1,084.70	**Benefit:** 75% = $813.55	85% = $1,023.20
	MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.) *(See para T4.3 of explanatory notes to this Category)*		
16525	**Fee:** $255.90	**Benefit:** 75% = $191.95	85% = $217.55
	POST-PARTUM CARE EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.) *(See para T4.6 of explanatory notes to this Category)*		
16564	**Fee:** $188.65	**Benefit:** 75% = $141.50	85% = $160.40
	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.) *(See para T4.6 of explanatory notes to this Category)*		
16567	**Fee:** $275.95	**Benefit:** 75% = $207.00	85% = $234.60
	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.) *(See para T4.6 of explanatory notes to this Category)*		
16570	**Fee:** $360.05	**Benefit:** 75% = $270.05	85% = $306.05
	CERVIX, repair of extensive laceration or lacerations (Anaes.) *(See para T4.6 of explanatory notes to this Category)*		
16571	**Fee:** $275.95	**Benefit:** 75% = $207.00	85% = $234.60
	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) *(See para T4.6 of explanatory notes to this Category)*		
16573	**Fee:** $224.90	**Benefit:** 75% = $168.70	85% = $191.20
*	PLANNING AND MANAGEMENT OF A PREGNANCY that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and/or delivery - payable once only for any pregnancy that has progressed beyond 20 weeks		
16590	**Fee:** $112.20	**Benefit:** 75% = $84.15	85% = $95.40
	INTERVENTIONAL TECHNIQUES AMNIOCENTESIS, diagnostic *(See para T4.7 of explanatory notes to this Category)*		
16600	**Fee:** $54.95	**Benefit:** 75% = $41.25	85% = $46.75

	CHORIONIC VILLUS SAMPLING, by any route *(See para T4.7 of explanatory notes to this Category)*		
16603	**Fee:** $105.50	**Benefit:** 75% = $79.15	85% = $89.70
	FETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.) *(See para T4.7 of explanatory notes to this Category)*		
16606	**Fee:** $210.50	**Benefit:** 75% = $157.90	85% = $178.95
	FETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.) *(See para T4.7 of explanatory notes to this Category)*		
16609	**Fee:** $429.25	**Benefit:** 75% = $321.95	85% = $367.75
	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.) *(See para T4.7 of explanatory notes to this Category)*		
16612	**Fee:** $337.70	**Benefit:** 75% = $253.30	85% = $287.05
	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.) *(See para T4.7 of explanatory notes to this Category)*		
16615	**Fee:** $179.85	**Benefit:** 75% = $134.90	85% = $152.90
	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated *(See para T4.7 of explanatory notes to this Category)*		
16618	**Fee:** $179.85	**Benefit:** 75% = $134.90	85% = $152.90
	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios *(See para T4.7 of explanatory notes to this Category)*		
16621	**Fee:** $179.85	**Benefit:** 75% = $134.90	85% = $152.90
	FETAL FLUID FILLED CAVITY, drainage of *(See para T4.7 of explanatory notes to this Category)*		
16624	**Fee:** $258.85	**Benefit:** 75% = $194.15	85% = $220.05
	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis *(See para T4.7 of explanatory notes to this Category)*		
16627	**Fee:** $527.05	**Benefit:** 75% = $395.30	85% = $465.55
	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606, 16609, 16612, 16615 and 16627 *(See para T4.7 of explanatory notes to this Category)*		
16633	**Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested		
	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600, 16603, 16618, 16621 and 16624 *(See para T4.7 of explanatory notes to this Category)*		
16636	**Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested		

	GROUP T6 - ANAESTHETICS
	SUBGROUP 1 - EXAMINATION BY AN ANAESTHETIST
17603	EXAMINATION OF A PATIENT IN PREPARATION FOR THE ADMINISTRATION OF AN ANAESTHETIC RELATING TO A CLINICALLY RELEVANT SERVICE, being an examination carried out at a place other than an operating theatre or an anaesthetic induction room *(See para T6.1 of explanatory notes to this Category)* **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
	GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS
18213	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion **Fee:** $76.75 **Benefit:** 75% = $57.60 85% = $65.25
18216	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.) **Fee:** $164.30 **Benefit:** 75% = $123.25 85% = $139.70
18219	INTRATHECAL or EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour (Anaes.) **Derived Fee:** The fee for item 18216 plus $16.50 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner
18222	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less *(See para T7.2 of explanatory notes to this Category)* **Fee:** $32.55 **Benefit:** 75% = $24.45 85% = $27.70
18225	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes *(See para T7.2 of explanatory notes to this Category)* **Fee:** $43.35 **Benefit:** 75% = $32.55 85% = $36.85
18226	**INTRATHECAL OR EPIDURAL INFUSION** of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, **for a patient in labour**, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. *(See para T7.4 of explanatory notes to this Category)* **Fee:** $246.45 **Benefit:** 75% = $184.85 85% = $209.50
18227	**INTRATHECAL OR EPIDURAL INFUSION** of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, **for a patient in labour**, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. *(See para T7.4 of explanatory notes to this Category)* **Derived Fee:** The fee for item 18226 plus $24.75 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner.
18228	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance **Fee:** $54.10 **Benefit:** 75% = $40.60 85% = $46.00
18230	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.) **Fee:** $206.35 **Benefit:** 75% = $154.80 85% = $175.40
18232	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.) *(See para T7.3 of explanatory notes to this Category)* **Fee:** $164.30 **Benefit:** 75% = $123.25 85% = $139.70
18233	EPIDURAL INJECTION of blood for blood patch (Anaes.) **Fee:** $164.30 **Benefit:** 75% = $123.25 85% = $139.70
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $108.05 **Benefit:** 75% = $81.05 85% = $91.85

18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $54.10	**Benefit:** 75% = $40.60	85% = $46.00
18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies *(See para T7.5 of explanatory notes to this Category)* **Fee:** $32.55	**Benefit:** 75% = $24.45	85% = $27.70
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $81.00	**Benefit:** 75% = $60.75	85% = $68.85
18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $32.55	**Benefit:** 75% = $24.45	85% = $27.70
18244	VAGUS NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.20	**Benefit:** 75% = $65.40	85% = $74.15
18246	GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.20	**Benefit:** 75% = $65.40	85% = $74.15
18248	PHRENIC NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $76.75	**Benefit:** 75% = $57.60	85% = $65.25
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $54.10	**Benefit:** 75% = $40.60	85% = $46.00
18252	CERVICAL PLEXUS, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.20	**Benefit:** 75% = $65.40	85% = $74.15
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.20	**Benefit:** 75% = $65.40	85% = $74.15
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $54.10	**Benefit:** 75% = $40.60	85% = $46.00
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $54.10	**Benefit:** 75% = $40.60	85% = $46.00
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $76.75	**Benefit:** 75% = $57.60	85% = $65.25
18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $54.10	**Benefit:** 75% = $40.60	85% = $46.00
18264	PUDENDAL NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.20	**Benefit:** 75% = $65.40	85% = $74.15
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 T7.5 of explanatory notes to this Category)* **Fee:** $54.10	**Benefit:** 75% = $40.60	85% = $46.00

18268	OBTURATOR NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $76.75	**Benefit:** 75% = $57.60	85% = $65.25
18270	FEMORAL NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $76.75	**Benefit:** 75% = $57.60	85% = $65.25
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $54.10	**Benefit:** 75% = $40.60	85% = $46.00
18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $76.75	**Benefit:** 75% = $57.60	85% = $65.25
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $108.05	**Benefit:** 75% = $81.05	85% = $91.85
18278	SCIATIC NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $76.75	**Benefit:** 75% = $57.60	85% = $65.25
18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $108.05	**Benefit:** 75% = $81.05	85% = $91.85
18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.20	**Benefit:** 75% = $65.40	85% = $74.15
18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $127.80	**Benefit:** 75% = $95.85	85% = $108.65
18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $127.80	**Benefit:** 75% = $95.85	85% = $108.65
18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $127.80	**Benefit:** 75% = $95.85	85% = $108.65
18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.) **Fee:** $216.15	**Benefit:** 75% = $162.15	85% = $183.75
18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin (Anaes.) **Fee:** $108.05	**Benefit:** 75% = $81.05	85% = $91.85
18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.) **Fee:** $152.30	**Benefit:** 75% = $114.25	85% = $129.50
18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $130.25	**Benefit:** 75% = $97.70	85% = $110.75
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $152.30	**Benefit:** 75% = $114.25	85% = $129.50

	BOTULINUM TOXIN		
	BOTULINUM TOXIN (Botox), injection of, for hemifacial spasm in a patient 12 years of age or older, including all injections on any one day *(See para T11 of explanatory notes to this Category)*		
18350	**Fee:** $108.05	**Benefit:** 75% = $81.05	85% = $91.85
H 18351	BOTULINUM TOXIN (Dysport), injection of, for the treatment of hemifacial spasm in a patient 18 years of age or older, including all such injections on any one day *(See para T11 of explanatory notes to this Category)*		
	Fee: $108.05	**Benefit:** 75% = $81.05	85% = $91.85
	BOTULINUM TOXIN (Botox or Dysport), injection of, for cervical dystonia (spasmodic torticollis), including all injections on any one day *(See para T11 of explanatory notes to this Category)*		
18352	**Fee:** $216.15	**Benefit:** 75% = $162.15	85% = $183.75
	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinus foot deformity due to spasticity in an ambulant cerebral palsy patient, between the ages of 2 and 17 (inclusive), including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.) *(See para T11 of explanatory notes to this Category)*		
18354	**Fee:** $108.05	**Benefit:** 75% = $81.05	85% = $91.85
	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovarus foot deformity due to spasticity in an ambulant cerebral palsy patient, between the ages of 2 and 17 (inclusive), including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day *(See para T11 of explanatory notes to this Category)* (Anaes.)		
18356	**Fee:** $108.05	**Benefit:** 75% = $81.05	85% = $91.85
	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovalgus foot deformity due to spasticity in an ambulant cerebral palsy patient, between the ages of 2 and 17 (inclusive), including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.) *(See para T11 of explanatory notes to this Category)*		
18358	**Fee:** $108.05	**Benefit:** 75% = $81.05	85% = $91.85
¶ 18360	BOTULINUM TOXIN (Botox), injection of, for the treatment of focal spasticity in adults, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb) *(See para T11 of explanatory notes to this Category)*		
	Fee: $108.05	**Benefit:** 75% = $81.05	85% = $91.85
¶ 18362	BOTULINUM TOXIN (Botox), injection of, for the treatment of severe primary hyperhidrosis of the axillae, including all such injections on any one day (Anaes.) *(See para T11 of explanatory notes to this Category)*		
	Fee: $213.50	**Benefit:** 75% = $160.15	85% = $181.50
¶ 18364	BOTULINUM TOXIN (Dysport), injection of, for treatment of spasticity of the arm in adults following a stroke, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb) *(See para T11 of explanatory notes to this Category)*		
	Fee: $108.05	**Benefit:** 75% = $81.05	85% = $91.85
¶ 18366	BOTULINUM TOXIN, injection of, for the treatment of strabismus in children and adults, including all such injections on any one day and associated electromyography (Anaes.) *(See para T11 of explanatory notes to this Category)*		
	Fee: $135.40	**Benefit:** 75% = $101.55	85% = $115.10
¶ 18368	BOTULINUM TOXIN, injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day *(See para T11 of explanatory notes to this Category)*		
	Fee: $231.10	**Benefit:** 75% = $173.35	85% = $196.45
18370	BOTULINUM TOXIN (Botox), injection of, for blepharospasm in a patient 12 years of age or older, including all such injections on any one day. (Anaes.) *(See para T11 of explanatory notes to this Category)*		
	Fee: $39.00	**Benefit:** 75% = $29.25	85% = $33.15
H 18371	BOTULINUM TOXIN (Dysport), injection of, for the treatment of blepharospasm in a patient 18 years of age or older, including all such injections on any one day (Anaes.) *(See para T11 of explanatory notes to this Category)*		
	Fee: $39.00	**Benefit:** 75% = $29.25	85% = $33.15

	GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE
	SUBGROUP 1 - HEAD
20100	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20102	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for plastic repair of cleft lip (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20104	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electroconvulsive therapy (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20120	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20124	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for otoscopy (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20140	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on eye, not being a service to which another item in this Group applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20142	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lens surgery (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20143	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for retinal surgery (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20144	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for corneal transplant (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20145	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vitrectomy (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20146	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for biopsy of conjunctiva (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20148	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for ophthalmoscopy (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
+ 20160	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nose or accessory sinuses, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20162	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical surgery on the nose and accessory sinuses (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20164	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
+ 20170	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20172	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of cleft palate (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20174	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision of retropharyngeal tumour (9 basic units) **Fee:** $154.35 **Benefit:** 75% = $115.80 85% = $131.20

20176	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical intraoral surgery (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20190	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20192	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20210	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20212	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for subdural taps (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20214	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for burr holes of the cranium (9 basic units) **Fee:** $154.35 **Benefit:** 75% = $115.80 85% = $131.20
20216	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units) **Fee:** $343.00 **Benefit:** 75% = $257.25 85% = $291.55
20220	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for spinal fluid shunt procedures (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20222	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for ablation of an intracranial nerve (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20225	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all cranial bone procedures (12 basic units) **Fee:** $205.80 **Benefit:** 75% = $154.35 85% = $174.95
	SUBGROUP 2 - NECK
20300	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20305	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20320	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20321	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20330	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laser surgery to the airway (excluding nose and mouth) (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20350	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20352	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for simple ligation of major vessels of neck (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90

	SUBGROUP 3 - THORAX
20400	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
20401	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20402	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for reconstructive procedures on breast (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20403	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20404	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for mastectomy (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20405	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for reconstructive procedures on the breast using myocutaneous flaps (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20406	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units) **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55
20410	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electrical conversion of arrhythmias (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20420	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20440	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the sternum (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20450	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on clavicle, scapula or sternum, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20452	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical surgery on clavicle, scapula or sternum (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20470	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for partial rib resection, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20472	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracoplasty (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20474	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures on chest wall (13 basic units) *(See para T10.22 of explanatory notes to this Category)* **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55
	SUBGROUP 4 - INTRATHORACIC
20500	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the oesophagus (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20520	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20522	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for needle biopsy of pleura (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35

20524	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pneumocentesis (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20526	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracoscopy (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20528	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for mediastinoscopy (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20540	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units) **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55
20542	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pulmonary decortication (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20546	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pulmonary resection with thoracoplasty (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20548	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intrathoracic repair of trauma to trachea and bronchi (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20560	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the heart, pericardium or great vessels of chest (20 basic units) **Fee:** $343.00 **Benefit:** 75% = $257.25 85% = $291.55
	SUBGROUP 5 - SPINE AND SPINAL CORD
20600	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20604	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for posterior cervical laminectomy with the patient in the sitting position (13 basic units) **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55
20620	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on thoracic spine and/or cord, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20622	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracolumbar sympathectomy (13 basic units) **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55
20630	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures in lumbar region, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20632	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lumbar sympathectomy (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20634	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for chemonucleolysis (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20670	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extensive spine and/or spinal cord procedures (13 basic units) *(See para T10.23 of explanatory notes to this Category)* **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55
20680	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for manipulation of spine when performed in the operating theatre of a hospital or day hospital facility (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
20690	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90

SUBGROUP 6 - UPPER ABDOMEN

20700	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
20702	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous liver biopsy (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
H 20703	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20705	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for diagnostic laparoscopy procedures (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20706	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laparoscopic procedures in the upper abdomen, not being a service to which another item in this Subgroup applies (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20730	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20740	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for upper gastrointestinal endoscopic procedures (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20745	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20750	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hernia repairs in upper abdomen, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20752	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of incisional hernia and/or wound dehiscence (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20754	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on an omphalocele (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20756	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transabdominal repair of diaphragmatic hernia (9 basic units) **Fee:** $154.35 **Benefit:** 75% = $115.80 85% = $131.20
20770	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major upper abdominal blood vessels (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20790	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures within the peritoneal cavity in upper abdomen including cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20791	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for gastric reduction or gastroplasty for the treatment of morbid obesity (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20792	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for partial hepatectomy (excluding liver biopsy) (13 basic units) **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55
20793	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extended or trisegmental hepatectomy (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20794	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pancreatectomy, partial or total (12 basic units) **Fee:** $205.80 **Benefit:** 75% = $154.35 85% = $174.95

20798	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for neuro endocrine tumour removal in the upper abdomen (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20799	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
	SUBGROUP 7 - LOWER ABDOMEN
20800	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
20802	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lipectomy of the lower abdomen (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
H 20803	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20805	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for diagnostic laparoscopic procedures (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20806	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laparoscopic procedures in the lower abdomen (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20810	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lower intestinal endoscopic procedures (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20815	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20820	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20830	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hernia repairs in lower abdomen, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20832	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20840	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures within the peritoneal cavity in lower abdomen including appendicectomy, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20841	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bowel resection, including laparoscopic bowel resection not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20842	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for amniocentesis (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20844	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20845	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical prostatectomy (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20846	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical hysterectomy (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80

H 20847	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for ovarian malignancy (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20848	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pelvic exenteration (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20850	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for Caesarean section (12 basic units) **Fee:** $205.80 **Benefit:** 75% = $154.35 85% = $174.95
20855	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for Caesarian hysterectomy or hysterectomy within 24 hours of delivery. (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20860	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20862	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for renal procedures, including upper 1/3 of ureter (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20864	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total cystectomy (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20866	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for adrenalectomy (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20867	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for neuro endocrine tumour removal in the lower abdomen (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20868	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for renal transplantation (donor or recipient) (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20880	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major lower abdominal vessels, not being a service to which another item in this subgroup applies (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
20882	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for inferior vena cava ligation (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20884	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous umbrella insertion (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20886	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
	SUBGROUP 8 - PERINEUM
20900	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the perineum (including biopsy of male genital system), not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
20902	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for anorectal procedures (including endoscopy and/or biopsy) (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20904	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20906	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vulvectomy (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20910	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35

20912	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral resection of bladder tumour(s) (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20914	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral resection of prostate (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20916	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bleeding post-transurethral resection (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
20920	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on male external genitalia, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
20924	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on undescended testis, unilateral or bilateral (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20926	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical orchidectomy, inguinal approach (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20928	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical orchidectomy, abdominal approach (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20930	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for orchiopexy, unilateral or bilateral (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20932	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20934	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20936	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20938	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for insertion of penile prosthesis (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
+ 20940	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for per vagina and vaginal procedures (including biopsy of labia, vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
+ 20942	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for colpotomy, colpectomy or colporrhaphy (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20943	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transvaginal assisted reproductive services (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20944	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal hysterectomy (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
20946	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal delivery (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
20948	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for purse string ligation of cervix, or removal of purse string ligature (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20950	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for culdoscopy (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20952	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hysteroscopy (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35

H 20953	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for endometrial ablation or resection in association with hysteroscopy (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20954	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for correction of inverted uterus (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
20956	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for evacuation of retained products of conception, as a complication of confinement (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
20958	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
20960	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
	SUBGROUP 9 - PELVIS (EXCEPT HIP)
21100	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21110	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21112	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21114	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21116	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow harvesting from the pelvis (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21120	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the bony pelvis (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21130	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for body cast application or revision when performed in the operating theatre of a hospital or day hospital facility (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21140	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for interpelviabdominal (hind-quarter) amputation (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
21150	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
21160	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital or day hospital facility (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21170	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
	SUBGROUP 10 - UPPER LEG (EXCEPT KNEE)
21195	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75

21199	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21200	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving hip joint when performed in the operating theatre of a hospital or day hospital facility (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21202	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of the hip joint (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21210	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21212	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hip disarticulation (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
21214	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total hip replacement or revision (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
H 21216	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bilateral total hip replacement (14 basic units) **Fee:** $240.10 **Benefit:** 75% = $180.10 85% = $204.10
21220	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital or day hospital facility (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21230	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving upper 2/3 of femur, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21232	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for above knee amputation (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21234	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection of the upper 2/3 of femur (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
21260	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures involving veins of upper leg, including exploration (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21270	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
21272	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for femoral artery ligation (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21274	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for femoral artery embolectomy (6 basic units) *(See para T10.24 of explanatory notes to this Category)* **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21280	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of upper leg (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
	SUBGROUP 11 - KNEE AND POPLITEAL AREA
21300	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21321	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35

21340	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital or day hospital facility (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21360	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on lower 1/3 of femur (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21380	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on knee joint when performed in the operating theatre of a hospital or day hospital facility (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21382	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of knee joint (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21390	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital or day hospital facility (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21392	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21400	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21402	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for knee replacement (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
21403	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bilateral knee replacement (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
21404	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for disarticulation of knee (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21420	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for cast application, removal, or repair involving knee joint, undertaken in a hospital or approved day hospital facility (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21430	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of knee or popliteal area, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21432	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of arteriovenous fistula of knee or popliteal area (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21440	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of knee or popliteal area, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
	SUBGROUP 12 - LOWER LEG (BELOW KNEE)
21460	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21461	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21462	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on lower leg, ankle, or foot (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21464	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedure of ankle joint (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35

21472	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of Achilles tendon (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21474	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for gastrocnemius recession (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21480	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21482	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection of bone involving lower leg, ankle or foot (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21484	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for osteotomy or osteoplasty of tibia or fibula (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21486	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total ankle replacement (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
21490	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lower leg cast application, removal or repair, undertaken in a hospital or approved day hospital facility (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21500	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
21502	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of the lower leg (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21520	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21522	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for venous thrombectomy of the lower leg (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21530	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of lower leg, ankle or foot (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
21532	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of toe (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
	SUBGROUP 13 - SHOULDER AND AXILLA
21600	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21610	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21620	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital or day hospital facility (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21622	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of shoulder joint (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21630	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90

21632	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21634	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder disarticulation (9 basic units) **Fee:** $154.35 **Benefit:** 75% = $115.80 85% = $131.20
21636	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for interthoracoscapular (forequarter) amputation (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
21638	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total shoulder replacement (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
21650	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of shoulder or axilla, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
21652	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures for axillary-brachial aneurysm (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
21654	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bypass graft of arteries of shoulder or axilla (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
21656	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for axillary-femoral bypass graft (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
21670	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of shoulder or axilla (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21680	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder cast application, removal or repair, not being a service to which another item in this Subgroup applies, when undertaken in a hospital or approved day hospital facility (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21682	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder spica application when undertaken in a hospital or approved day hospital facility (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
	SUBGROUP 14 - UPPER ARM AND ELBOW
21700	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21710	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21712	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open tenotomy of the upper arm or elbow (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21714	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for tenoplasty of the upper arm or elbow (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21716	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for tenodesis for rupture of long tendon of biceps (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21730	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital or day hospital facility (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21732	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of elbow joint (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21740	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90

21756	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures on the upper arm or elbow (6 basic units) **Fee:** $102.90	**Benefit:** 75% = $77.20	85% = $87.50
21760	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total elbow replacement (7 basic units) **Fee:** $120.05	**Benefit:** 75% = $90.05	85% = $102.05
21770	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of upper arm, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $137.20	**Benefit:** 75% = $102.90	85% = $116.65
21772	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of arteries of the upper arm (6 basic units) **Fee:** $102.90	**Benefit:** 75% = $77.20	85% = $87.50
21780	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of upper arm, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
21790	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of upper arm (15 basic units) **Fee:** $257.25	**Benefit:** 75% = $192.95	85% = $218.70
	SUBGROUP 15 - FOREARM WRIST AND HAND		
21800	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units) **Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
21810	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units) **Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
21820	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital or day hospital facility (3 basic units) **Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
21830	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
21832	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total wrist replacement (7 basic units) **Fee:** $120.05	**Benefit:** 75% = $90.05	85% = $102.05
21834	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of the wrist joint (4 basic units) **Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
21840	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $137.20	**Benefit:** 75% = $102.90	85% = $116.65
21842	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of artery of forearm, wrist or hand (6 basic units) **Fee:** $102.90	**Benefit:** 75% = $77.20	85% = $87.50
21850	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
21860	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for forearm, wrist, or hand cast application, removal, or repair when undertaken in a hospital or approved day hospital facility (3 basic units) **Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
21870	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of forearm, wrist or hand (15 basic units) **Fee:** $257.25	**Benefit:** 75% = $192.95	85% = $218.70
21872	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of a finger (8 basic units) **Fee:** $137.20	**Benefit:** 75% = $102.90	85% = $116.65

	SUBGROUP 16 - ANAESTHESIA FOR BURNS
21878	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21879	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting,where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21880	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
21881	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units) **Fee:** $154.35 **Benefit:** 75% = $115.80 85% = $131.20
21882	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units) **Fee:** $188.65 **Benefit:** 75% = $141.50 85% = $160.40
21883	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units) **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55
21884	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
21885	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units) **Fee:** $291.55 **Benefit:** 75% = $218.70 85% = $247.85
21886	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units) **Fee:** $325.85 **Benefit:** 75% = $244.40 85% = $277.00
21887	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic units) **Fee:** $360.15 **Benefit:** 75% = $270.15 85% = $306.15
	SUBGROUP 17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
21900	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for hysterosalpingography (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21906	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: lumbar or thoracic (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21908	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: cervical (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21910	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: posterior fossa (9 basic units) **Fee:** $154.35 **Benefit:** 75% = $115.80 85% = $131.20
21912	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for discography: lumbar or thoracic (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21914	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for discography: cervical (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21915	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for peripheral arteriogram (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90

21916	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arteriograms: cerebral, carotid or vertebral (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21918	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for retrograde arteriogram: brachial or femoral (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21922	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (7 basic units) **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
21925	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21926	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for fluoroscopy (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21927	**INITIATION OF MANAGEMENT OF ANAESTHESIA** forl barium enema or other opaque study of the small bowel (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21930	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bronchography (6 basic units) **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21935	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for phlebography (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21936	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for heart, 2 dimensional real time transoesophageal examination (6 basic units) *(See para T10.26 of explanatory notes to this Category)* **Fee:** $102.90 **Benefit:** 75% = $77.20 85% = $87.50
21939	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for peripheral venous cannulation (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21941	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (7 basic units) *(See para T10.25 of explanatory notes to this Category)* **Fee:** $120.05 **Benefit:** 75% = $90.05 85% = $102.05
21942	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for cardiac electrophysiological procedures including radio frequency ablation (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
21943	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21945	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lumbar puncture, cisternal puncture, or epidural injection (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21949	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for harvesting of bone marrow for the purpose of transplantation (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21952	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for muscle biopsy for malignant hyperpyrexia (10 basic units) **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
21955	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electroencephalography (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21959	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for brain stem evoked response audiometry (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90

21962	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
I 21965	**INITIATION OF MANAGEMENT OF ANAESTHESIA** as a therapeutic procedure **where it can be demonstrated that there is a clinical need for anaesthesia, not for the treatment of headache of any etiology** (5 basic units) *(See para T10.11 of explanatory notes to this Category)* **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21969	**INITIATION OF MANAGEMENT OF ANAESTHESIA** during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units) **Fee:** $137.20 **Benefit:** 75% = $102.90 85% = $116.65
21970	**INITIATION OF MANAGEMENT OF ANAESTHESIA** during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (15 basic units) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
21973	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for brachytherapy using radioactive sealed sources (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21976	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for therapeutic nuclear medicine (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
21980	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radiotherapy (5 basic units) **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
	SUBGROUP 18 - MISCELLANEOUS
21990	**INITIATION OF MANAGEMENT OF ANAESTHESIA** when no procedure ensues (3 basic units) *(See para T10.12 of explanatory notes to this Category)* **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
21992	**INITIATION OF MANAGEMENT OF ANAESTHESIA** performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
21997	**INITIATION OF MANAGEMENT OF ANAESTHESIA** in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic rebate, not being a service to which item 21992 or 21965 applies **where it can be demonstrated that there is a clinical need for anaesthesia** (4 basic units) *(See para T10.13 of explanatory notes to this Category)* **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
	SUBGROUP 19 - THERAPEUTIC AND DIAGNOSTIC SERVICES
22001	**COLLECTION OF BLOOD FOR AUTOLOGOUS TRANSFUSION** or when homologous blood is required for immediate transfusion in an emergency situation, **when performed in association with the administration of anaesthesia** (3 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
22002	**ADMINISTRATION OF BLOOD** or bone marrow already collected **when performed in association with the administration of anaesthesia** (4 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
22007	**AWAKE ENDOTRACHEAL INTUBATION** with flexible fibreoptic scope associated with difficult **airway when performed in association with the administration of anaesthesia** (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
22008	**DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER,** insertion of when **performed in association with the administration of anaesthesia** (4 basic units) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
22012	**BLOOD PRESSURE MONITORING** (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) **when performed in association with the administration of anaesthesia** (3 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75

22014	**BLOOD PRESSURE MONITORING** (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) **when performed in association with the administration of anaesthesia relating to another discrete operation on the same day** (3 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
22015	**RIGHT HEART BALLOON CATHETER,** insertion of, including pulmonary wedge pressure and cardiac output measurement, **when performed in association with the administration of anaesthesia** (6 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $102.90	**Benefit:** 75% = $77.20	85% = $87.50
H 22018	**MEASUREMENT OF THE MECHANICAL OR GAS EXCHANGE FUNCTION OF THE RESPIRATORY SYSTEM**, using measurements of parameters, including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood and incorporating serial arterial blood gas analysis and a written record of the results, when performed in association with the administration of anaesthesia, not being a service associated with a service to which item 11503 applies (7 basic units) **Fee:** $120.05	**Benefit:** 75% = $90.05	85% = $102.05
22020	**CENTRAL VEIN CATHETERISATION** (via jugular, subclavian or femoral vein) by percutaneous or open exposure, not being a service to which item 13318 applies, **when performed in association with the administration of anaesthesia** (4 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
22025	**INTRAARTERIAL CANNULATION when performed in association with the administration of anaesthesia** (4 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
H 22031	**INTRATHECAL or EPIDURAL INJECTION** (initial) of a therapeutic substance or substances, with or without insertion of a catheter, **in association with anaesthesia and surgery**, for postoperative pain management, not being a service associated with a service to which 22036 applies (5 basic units) **Fee:** $85.75	**Benefit:** 75% = $64.35	85% = $72.90
H 22036	**INTRATHECAL or EPIDURAL INJECTION** (subsequent) of a therapeutic substance or substances, using an in-situ catheter, **in association with anaesthesia and surgery**, for postoperative pain management, not being a service associated with a service to which 22031 applies (3 basic units) **Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
22040	**INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK** peri-operatively performed in the induction room theatre or recovery room for the control of post operative pain via the femoral **OR** sciatic nerves, **in conjunction with hip, knee, ankle or foot surgery** (2 basic units) *(See para T10.17 and T10.21 of explanatory notes to this Category)* **Fee:** $34.30	**Benefit:** 75% = $25.75	85% = $29.20
22045	**INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK** peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral **AND** sciatic nerves, **in conjunction with hip, knee, ankle or foot surgery** (3 basic units) *(See para T10.17 and T10.21 of explanatory notes to this Category)* **Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
22050	**INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK** peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus **in conjunction with shoulder surgery** (2 basic units) *(See para T10.17 and T10.21 of explanatory notes to this Category)* **Fee:** $34.30	**Benefit:** 75% = $25.75	85% = $29.20
22055	**PERFUSION OF LIMB OR ORGAN** using heart-lung machine or equivalent (12 basic units) **Fee:** $205.80	**Benefit:** 75% = $154.35	85% = $174.95
22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, using heart-lung machine or equivalent (20 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $343.00	**Benefit:** 75% = $257.25	85% = $291.55
22065	**INDUCED CONTROLLED HYPOTHERMIA** total body (5 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $85.75	**Benefit:** 75% = $64.35	85% = $72.90

	CARDIOPLEGIA, blood or crystalloid, administration by any route (10 basic units) *(See para T10.10 of explanatory notes to this Category)*		
22070	**Fee:** $171.50	**Benefit:** 75% = $128.65	85% = $145.80
	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed (15 basic units) *(See para T10.10 of explanatory notes to this Category)*		
22075	**Fee:** $257.25	**Benefit:** 75% = $192.95	85% = $218.70
	SUBGROUP 20 - ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE		
	INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units) *(See para T10.14 of explanatory notes to this Category)*		
+ 22900	**Fee:** $102.90	**Benefit:** 75% = $77.20	85% = $87.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units) *(See para T10.14 of explanatory notes to this Category)*		
+ 22905	**Fee:** $102.90	**Benefit:** 75% = $77.20	85% = $87.50
	SUBGROUP 21 - ANAESTHESIA/PERFUSION TIME UNITS		
	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 For a period of: (FIFTEEN MINUTES OR LESS) (1 basic units) *(See para T10.3 of explanatory notes to this Category)*		
23010	**Fee:** $17.15	**Benefit:** 75% = $12.90	85% = $14.60
	16 MINUTES TO 20 MINUTES (2 basic units)		
23021	**Fee:** $34.30	**Benefit:** 75% = $25.75	85% = $29.20
	21 MINUTES TO 25 MINUTES (2 basic units)		
23022	**Fee:** $34.30	**Benefit:** 75% = $25.75	85% = $29.20
	26 MINUTES TO 30 MINUTES (2 basic units)		
23023	**Fee:** $34.30	**Benefit:** 75% = $25.75	85% = $29.20
	31 MINUTES TO 35 MINUTES (3 basic units)		
23031	**Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
	36 MINUTES TO 40 MINUTES (3 basic units)		
23032	**Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
	41 MINUTES TO 45 MINUTES (3 basic units)		
23033	**Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
	46 MINUTES TO 50 MINUTES (4 basic units)		
23041	**Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
	51 MINUTES TO 55 MINUTES (4 basic units)		
23042	**Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
	56 MINUTES TO 1:00 HOUR (4 basic units)		
23043	**Fee:** $68.60	**Benefit:** 75% = $51.45	85% = $58.35
	1:01 HOURS TO 1:05 HOURS (5 basic units)		
23051	**Fee:** $85.75	**Benefit:** 75% = $64.35	85% = $72.90
	1:06 HOURS TO 1:10 HOURS (5 basic units)		
23052	**Fee:** $85.75	**Benefit:** 75% = $64.35	85% = $72.90

23053	1:11 HOURS TO 1:15 HOURS (5 basic units) **Fee:** $85.75	**Benefit:** 75% = $64.35	85% = $72.90
23061	1:16 HOURS TO 1:20 HOURS (6 basic units) **Fee:** $102.90	**Benefit:** 75% = $77.20	85% = $87.50
23062	1:21 HOURS TO 1:25 HOURS (6 basic units) **Fee:** $102.90	**Benefit:** 75% = $77.20	85% = $87.50
23063	1:26 HOURS TO 1:30 HOURS (6 basic units) **Fee:** $102.90	**Benefit:** 75% = $77.20	85% = $87.50
23071	1:31 HOURS TO 1:35 HOURS (7 basic units) **Fee:** $120.05	**Benefit:** 75% = $90.05	85% = $102.05
23072	1:36 HOURS TO 1:40 HOURS (7 basic units) **Fee:** $120.05	**Benefit:** 75% = $90.05	85% = $102.05
23073	1:41 HOURS TO 1:45 HOURS (7 basic units) **Fee:** $120.05	**Benefit:** 75% = $90.05	85% = $102.05
23081	1:46 HOURS TO 1:50 HOURS (8 basic units) **Fee:** $137.20	**Benefit:** 75% = $102.90	85% = $116.65
23082	1:51 HOURS TO 1:55 HOURS (8 basic units) **Fee:** $137.20	**Benefit:** 75% = $102.90	85% = $116.65
23083	1:56 HOURS TO 2:00 HOURS (8 basic units) **Fee:** $137.20	**Benefit:** 75% = $102.90	85% = $116.65
H 23091	2:01 HOURS TO 2:10 HOURS (9 basic units) **Fee:** $154.35	**Benefit:** 75% = $115.80	85% = $131.20
H 23101	2:11 HOURS TO 2:20 HOURS (10 basic units) **Fee:** $171.50	**Benefit:** 75% = $128.65	85% = $145.80
H 23111	2:21 HOURS TO 2:30 HOURS (11 basic units) **Fee:** $188.65	**Benefit:** 75% = $141.50	85% = $160.40
H 23112	2:31 HOURS TO 2:40 HOURS (12 basic units) **Fee:** $205.80	**Benefit:** 75% = $154.35	85% = $174.95
H 23113	2:41 HOURS TO 2:50 HOURS (13 basic units) **Fee:** $222.95	**Benefit:** 75% = $167.25	85% = $189.55
H 23114	2:51 HOURS TO 3:00 HOURS (14 basic units) **Fee:** $240.10	**Benefit:** 75% = $180.10	85% = $204.10
H 23115	3:01 HOURS TO 3:10 HOURS (15 basic units) **Fee:** $257.25	**Benefit:** 75% = $192.95	85% = $218.70
H 23116	3:11 HOURS TO 3:20 HOURS (16 basic units) **Fee:** $274.40	**Benefit:** 75% = $205.80	85% = $233.25
H 23117	3:21 HOURS TO 3:30 HOURS (17 basic units) **Fee:** $291.55	**Benefit:** 75% = $218.70	85% = $247.85
H 23118	3:31 HOURS TO 3:40 HOURS (18 basic units) **Fee:** $308.70	**Benefit:** 75% = $231.55	85% = $262.40
H 23119	3:41 HOURS TO 3:50 HOURS (19 basic units) **Fee:** $325.85	**Benefit:** 75% = $244.40	85% = $277.00
H 23121	3:51 HOURS TO 4:00 HOURS (20 basic units) **Fee:** $343.00	**Benefit:** 75% = $257.25	85% = $291.55

+ 23170	4:01 HOURS TO 4:10 HOURS (21 basic units) **Fee:** $360.15	**Benefit:** 75% = $270.15	85% = $306.15
+ 23180	4:11 HOURS TO 4:20 HOURS (22 basic units) **Fee:** $377.30	**Benefit:** 75% = $283.00	85% = $320.75
+ 23190	4:21 HOURS TO 4:30 HOURS (23 basic units) **Fee:** $394.45	**Benefit:** 75% = $295.85	85% = $335.30
+ 23200	4:31 HOURS TO 4:40 HOURS (24 basic units) **Fee:** $411.60	**Benefit:** 75% = $308.70	85% = $350.10
+ 23210	4:41 HOURS TO 4:50 HOURS (25 basic units) **Fee:** $428.75	**Benefit:** 75% = $321.60	85% = $367.25
+ 23220	4:51 HOURS TO 5:00 HOURS (26 basic units) **Fee:** $445.90	**Benefit:** 75% = $334.45	85% = $384.40
+ 23230	5:01 HOURS TO 5:10 HOURS (27 basic units) **Fee:** $463.05	**Benefit:** 75% = $347.30	85% = $401.55
+ 23240	5:11 HOURS TO 5:20 HOURS (28 basic units) **Fee:** $480.20	**Benefit:** 75% = $360.15	85% = $418.70
+ 23250	5:21 HOURS TO 5:30 HOURS (29 basic units) **Fee:** $497.35	**Benefit:** 75% = $373.05	85% = $435.85
+ 23260	5:31 HOURS TO 5:40 HOURS (30 basic units) **Fee:** $514.50	**Benefit:** 75% = $385.90	85% = $453.00
+ 23270	5:41 HOURS TO 5:50 HOURS (31 basic units) **Fee:** $531.65	**Benefit:** 75% = $398.75	85% = $470.15
+ 23280	(5:51 HOURS TO 6:00 HOURS (32 basic units) **Fee:** $548.80	**Benefit:** 75% = $411.60	85% = $487.30
+ 23290	6:01 HOURS TO 6:10 HOURS (33 basic units) **Fee:** $565.95	**Benefit:** 75% = $424.50	85% = $504.45
+ 23300	6:11 HOURS TO 6:20 HOURS (34 basic units) **Fee:** $583.10	**Benefit:** 75% = $437.35	85% = $521.60
+ 23310	6:21 HOURS TO 6:30 HOURS (35 basic units) **Fee:** $600.25	**Benefit:** 75% = $450.20	85% = $538.75
+ 23320	6:31 HOURS TO 6:40 HOURS (36 basic units) **Fee:** $617.40	**Benefit:** 75% = $463.05	85% = $555.90
+ 23330	6:41 HOURS TO 6:50 HOURS (37 basic units) **Fee:** $634.55	**Benefit:** 75% = $475.95	85% = $573.05
+ 23340	6:51 HOURS TO 7:00 HOURS (38 basic units) **Fee:** $651.70	**Benefit:** 75% = $488.80	85% = $590.20
+ 23350	7:01 HOURS TO 7:10 HOURS (39 basic units) **Fee:** $668.85	**Benefit:** 75% = $501.65	85% = $607.35
+ 23360	7:11 HOURS TO 7:20 HOURS (40 basic units) **Fee:** $686.00	**Benefit:** 75% = $514.50	85% = $624.50
+ 23370	7:21 HOURS TO 7:30 HOURS (41 basic units) **Fee:** $703.15	**Benefit:** 75% = $527.40	85% = $641.65
+ 23380	7:31 HOURS TO 7:40 HOURS (42 basic units) **Fee:** $720.30	**Benefit:** 75% = $540.25	85% = $658.80

+ 23390	7:41 HOURS TO 7:50 HOURS (43 basic units) **Fee:** $737.45	**Benefit:** 75% = $553.10	85% = $675.95
+ 23400	7:51 HOURS TO 8:00 HOURS (44 basic units) **Fee:** $754.60	**Benefit:** 75% = $565.95	85% = $693.10
+ 23410	8:01 HOURS TO 8:10 HOURS (45 basic units) **Fee:** $771.75	**Benefit:** 75% = $578.85	85% = $710.25
+ 23420	8:11 HOURS TO 8:20 HOURS (46 basic units) **Fee:** $788.90	**Benefit:** 75% = $591.70	85% = $727.40
+ 23430	8:21 HOURS TO 8:30 HOURS (47 basic units) **Fee:** $806.05	**Benefit:** 75% = $604.55	85% = $744.55
+ 23440	8:31 HOURS TO 8:40 HOURS (48 basic units) **Fee:** $823.20	**Benefit:** 75% = $617.40	85% = $761.70
+ 23450	8:41 HOURS TO 8:50 HOURS (49 basic units) **Fee:** $840.35	**Benefit:** 75% = $630.30	85% = $778.85
+ 23460	8:51 HOURS TO 9:00 HOURS (50 basic units) **Fee:** $857.50	**Benefit:** 75% = $643.15	85% = $796.00
+ 23470	9:01 HOURS TO 9:10 HOURS (51 basic units) **Fee:** $874.65	**Benefit:** 75% = $656.00	85% = $813.15
+ 23480	9:11 HOURS TO 9:20 HOURS (52 basic units) **Fee:** $891.80	**Benefit:** 75% = $668.85	85% = $830.30
+ 23490	9:21 HOURS TO 9:30 HOURS (53 basic units) **Fee:** $908.95	**Benefit:** 75% = $681.75	85% = $847.45
+ 23500	9:31 HOURS TO 9:40 HOURS (54 basic units) **Fee:** $926.10	**Benefit:** 75% = $694.60	85% = $864.60
+ 23510	9:41 HOURS TO 9:50 HOURS (55 basic units) **Fee:** $943.25	**Benefit:** 75% = $707.45	85% = $881.75
+ 23520	9:51 HOURS TO 10:00 HOURS (56 basic units) **Fee:** $960.40	**Benefit:** 75% = $720.30	85% = $898.90
+ 23530	10:01 HOURS TO 10:10 HOURS (57 basic units) **Fee:** $977.55	**Benefit:** 75% = $733.20	85% = $916.05
+ 23540	10:11 HOURS TO 10:20 HOURS (58 basic units) **Fee:** $994.70	**Benefit:** 75% = $746.05	85% = $933.20
+ 23550	10:21 HOURS TO 10:30 HOURS (59 basic units) **Fee:** $1,011.85	**Benefit:** 75% = $758.90	85% = $950.35
+ 23560	10:31 HOURS TO 10:40 HOURS (60 basic units) **Fee:** $1,029.00	**Benefit:** 75% = $771.75	85% = $967.50
+ 23570	10:41 HOURS TO 10:50 HOURS (61 basic units) **Fee:** $1,046.15	**Benefit:** 75% = $784.65	85% = $984.65
+ 23580	10:51 HOURS TO 11:00 HOURS (62 basic units) **Fee:** $1,063.30	**Benefit:** 75% = $797.50	85% = $1,001.80
+ 23590	11:01 HOURS TO 11:10 HOURS (63 basic units) **Fee:** $1,080.45	**Benefit:** 75% = $810.35	85% = $1,018.95
+ 23600	11:11 HOURS TO 11:20 HOURS (64 basic units) **Fee:** $1,097.60	**Benefit:** 75% = $823.20	85% = $1,036.10

+ 23610	11:21 HOURS TO 11:30 HOURS (65 basic units) **Fee:** $1,114.75	**Benefit:** 75% = $836.10	85% = $1,053.25
+ 23620	11:31 HOURS TO 11:40 HOURS (66 basic units) **Fee:** $1,131.90	**Benefit:** 75% = $848.95	85% = $1,070.40
+ 23630	11:41 HOURS TO 11:50 HOURS (67 basic units) **Fee:** $1,149.05	**Benefit:** 75% = $861.80	85% = $1,087.55
+ 23640	11:51 HOURS TO 12:00 HOURS (68 basic units) **Fee:** $1,166.20	**Benefit:** 75% = $874.65	85% = $1,104.70
+ 23650	12:01 HOURS TO 12:10 HOURS (69 basic units) **Fee:** $1,183.35	**Benefit:** 75% = $887.55	85% = $1,121.85
+ 23660	12:11 HOURS TO 12:20 HOURS (70 basic units) **Fee:** $1,200.50	**Benefit:** 75% = $900.40	85% = $1,139.00
+ 23670	12:21 HOURS TO 12:30 HOURS (71 basic units) **Fee:** $1,217.65	**Benefit:** 75% = $913.25	85% = $1,156.15
+ 23680	12:31 HOURS TO 12:40 HOURS (72 basic units) **Fee:** $1,234.80	**Benefit:** 75% = $926.10	85% = $1,173.30
+ 23690	12:41 HOURS TO 12:50 HOURS (73 basic units) **Fee:** $1,251.95	**Benefit:** 75% = $939.00	85% = $1,190.45
+ 23700	12:51 HOURS TO 13:00 HOURS (74 basic units) **Fee:** $1,269.10	**Benefit:** 75% = $951.85	85% = $1,207.60
+ 23710	13:01 HOURS TO 13:10 HOURS (75 basic units) **Fee:** $1,286.25	**Benefit:** 75% = $964.70	85% = $1,224.75
+ 23720	13:11 HOURS TO 13:20 HOURS (76 basic units) **Fee:** $1,303.40	**Benefit:** 75% = $977.55	85% = $1,241.90
+ 23730	13:21 HOURS TO 13:30 HOURS (77 basic units) **Fee:** $1,320.55	**Benefit:** 75% = $990.45	85% = $1,259.05
+ 23740	13:31 HOURS TO 13:40 HOURS (78 basic units) **Fee:** $1,337.70	**Benefit:** 75% = $1,003.30	85% = $1,276.20
+ 23750	13:41 HOURS TO 13:50 HOURS (79 basic units) **Fee:** $1,354.85	**Benefit:** 75% = $1,016.15	85% = $1,293.35
+ 23760	13:51 HOURS TO 14:00 HOURS (80 basic units) **Fee:** $1,372.00	**Benefit:** 75% = $1,029.00	85% = $1,310.50
+ 23770	14:01 HOURS TO 14:10 HOURS (81 basic units) **Fee:** $1,389.15	**Benefit:** 75% = $1,041.90	85% = $1,327.65
+ 23780	14:11 HOURS TO 14:20 HOURS (82 basic units) **Fee:** $1,406.30	**Benefit:** 75% = $1,054.75	85% = $1,344.80
+ 23790	14:21 HOURS TO 14:30 HOURS (83 basic units) **Fee:** $1,423.45	**Benefit:** 75% = $1,067.60	85% = $1,361.95
+ 23800	14:31 HOURS TO 14:40 HOURS (84 basic units) **Fee:** $1,440.60	**Benefit:** 75% = $1,080.45	85% = $1,379.10
+ 23810	14:41 HOURS TO 14:50 HOURS (85 basic units) **Fee:** $1,457.75	**Benefit:** 75% = $1,093.35	85% = $1,396.25
+ 23820	14:51 HOURS TO 15:00 HOURS (86 basic units) **Fee:** $1,474.90	**Benefit:** 75% = $1,106.20	85% = $1,413.40

+ 23830	15:01 HOURS TO 15:10 HOURS (87 basic units) **Fee:** $1,492.05	**Benefit:** 75% = $1,119.05	85% = $1,430.55
+ 23840	15:11 HOURS TO 15:20 HOURS (88 basic units) **Fee:** $1,509.20	**Benefit:** 75% = $1,131.90	85% = $1,447.70
+ 23850	15:21 HOURS TO 15:30 HOURS (89 basic units) **Fee:** $1,526.35	**Benefit:** 75% = $1,144.80	85% = $1,464.85
+ 23860	15:31 HOURS TO 15:40 HOURS (90 basic units) **Fee:** $1,543.50	**Benefit:** 75% = $1,157.65	85% = $1,482.00
+ 23870	15:41 HOURS TO 15:50 HOURS (91 basic units) **Fee:** $1,560.65	**Benefit:** 75% = $1,170.50	85% = $1,499.15
+ 23880	15:51 HOURS TO 16:00 HOURS (92 basic units) **Fee:** $1,577.80	**Benefit:** 75% = $1,183.35	85% = $1,516.30
+ 23890	16:01 HOURS TO 16:10 HOURS (93 basic units) **Fee:** $1,594.95	**Benefit:** 75% = $1,196.25	85% = $1,533.45
+ 23900	16:11 HOURS TO 16:20 HOURS (94 basic units) **Fee:** $1,612.10	**Benefit:** 75% = $1,209.10	85% = $1,550.60
+ 23910	16:21 HOURS TO 16:30 HOURS (95 basic units) **Fee:** $1,629.25	**Benefit:** 75% = $1,221.95	85% = $1,567.75
+ 23920	16:31 HOURS TO 16:40 HOURS (96 basic units) **Fee:** $1,646.40	**Benefit:** 75% = $1,234.80	85% = $1,584.90
+ 23930	16:41 HOURS TO 16:50 HOURS (97 basic units) **Fee:** $1,663.55	**Benefit:** 75% = $1,247.70	85% = $1,602.05
+ 23940	16:51 HOURS TO 17:00 HOURS (98 basic units) **Fee:** $1,680.70	**Benefit:** 75% = $1,260.55	85% = $1,619.20
+ 23950	17:01 HOURS TO 17:10 HOURS (99 basic units) **Fee:** $1,697.85	**Benefit:** 75% = $1,273.40	85% = $1,636.35
+ 23960	17:11 HOURS TO 17:20 HOURS (100 basic units) **Fee:** $1,715.00	**Benefit:** 75% = $1,286.25	85% = $1,653.50
+ 23970	17:21 HOURS TO 17:30 HOURS (101 basic units) **Fee:** $1,732.15	**Benefit:** 75% = $1,299.15	85% = $1,670.65
+ 23980	17:31 HOURS TO 17:40 HOURS (102 basic units) **Fee:** $1,749.30	**Benefit:** 75% = $1,312.00	85% = $1,687.80
+ 23990	17:41 HOURS TO 17:50 HOURS (103 basic units) **Fee:** $1,766.45	**Benefit:** 75% = $1,324.85	85% = $1,704.95
+ 24100	17:51 HOURS TO 18:00 HOURS (104 basic units) **Fee:** $1,783.60	**Benefit:** 75% = $1,337.70	85% = $1,722.10
+ 24101	18:01 HOURS TO 18:10 HOURS (105 basic units) **Fee:** $1,800.75	**Benefit:** 75% = $1,350.60	85% = $1,739.25
+ 24102	18:11 HOURS TO 18:20 HOURS (106 basic units) **Fee:** $1,817.90	**Benefit:** 75% = $1,363.45	85% = $1,756.40
+ 24103	18:21 HOURS TO 18:30 HOURS (107 basic units) **Fee:** $1,835.05	**Benefit:** 75% = $1,376.30	85% = $1,773.55
+ 24104	18:31 HOURS TO 18:40 HOURS (108 basic units) **Fee:** $1,852.20	**Benefit:** 75% = $1,389.15	85% = $1,790.70

+ 24105	18:41 HOURS TO 18:50 HOURS (109 basic units) **Fee:** $1,869.35	**Benefit:** 75% = $1,402.05	85% = $1,807.85
+ 24106	18:51 HOURS TO 19:00 HOURS (110 basic units) **Fee:** $1,886.50	**Benefit:** 75% = $1,414.90	85% = $1,825.00
+ 24107	19:01 HOURS TO 19:10 HOURS (111 basic units) **Fee:** $1,903.65	**Benefit:** 75% = $1,427.75	85% = $1,842.15
+ 24108	19:11 HOURS TO 19:20 HOURS (112 basic units) **Fee:** $1,920.80	**Benefit:** 75% = $1,440.60	85% = $1,859.30
+ 24109	19:21 HOURS TO 19:30 HOURS (113 basic units) **Fee:** $1,937.95	**Benefit:** 75% = $1,453.50	85% = $1,876.45
+ 24110	19:31 HOURS TO 19:40 HOURS (114 basic units) **Fee:** $1,955.10	**Benefit:** 75% = $1,466.35	85% = $1,893.60
+ 24111	19:41 HOURS TO 19:50 HOURS (115 basic units) **Fee:** $1,972.25	**Benefit:** 75% = $1,479.20	85% = $1,910.75
+ 24112	19:51 HOURS TO 20:00 HOURS (116 basic units) **Fee:** $1,989.40	**Benefit:** 75% = $1,492.05	85% = $1,927.90
+ 24113	20:01 HOURS TO 20:10 HOURS (117 basic units) **Fee:** $2,006.55	**Benefit:** 75% = $1,504.95	85% = $1,945.05
+ 24114	20:11 HOURS TO 20:20 HOURS (118 basic units) **Fee:** $2,023.70	**Benefit:** 75% = $1,517.80	85% = $1,962.20
+ 24115	20:21 HOURS TO 20:30 HOURS (119 basic units) **Fee:** $2,040.85	**Benefit:** 75% = $1,530.65	85% = $1,979.35
+ 24116	20:31 HOURS TO 20:40 HOURS (120 basic units) **Fee:** $2,058.00	**Benefit:** 75% = $1,543.50	85% = $1,996.50
+ 24117	20:41 HOURS TO 20:50 HOURS (121 basic units) **Fee:** $2,075.15	**Benefit:** 75% = $1,556.40	85% = $2,013.65
+ 24118	20:51 HOURS TO 21:00 HOURS (122 basic units) **Fee:** $2,092.30	**Benefit:** 75% = $1,569.25	85% = $2,030.80
+ 24119	21:01 HOURS TO 21:10 HOURS (123 basic units) **Fee:** $2,109.45	**Benefit:** 75% = $1,582.10	85% = $2,047.95
+ 24120	21:11 HOURS TO 21:20 HOURS (124 basic units) **Fee:** $2,126.60	**Benefit:** 75% = $1,594.95	85% = $2,065.10
+ 24121	21:21 HOURS TO 21:30 HOURS (125 basic units) **Fee:** $2,143.75	**Benefit:** 75% = $1,607.85	85% = $2,082.25
+ 24122	21:31 HOURS TO 21:40 HOURS (126 basic units) **Fee:** $2,160.90	**Benefit:** 75% = $1,620.70	85% = $2,099.40
+ 24123	21:41 HOURS TO 21:50 HOURS (127 basic units) **Fee:** $2,178.05	**Benefit:** 75% = $1,633.55	85% = $2,116.55
+ 24124	21:51 HOURS TO 22:00 HOURS (128 basic units) **Fee:** $2,195.20	**Benefit:** 75% = $1,646.40	85% = $2,133.70
+ 24125	22:01 HOURS TO 22:10 HOURS (129 basic units) **Fee:** $2,212.35	**Benefit:** 75% = $1,659.30	85% = $2,150.85
+ 24126	22:11 HOURS TO 22:20 HOURS (130 basic units) **Fee:** $2,229.50	**Benefit:** 75% = $1,672.15	85% = $2,168.00

+ 24127	22:21 HOURS TO 22:30 HOURS (131 basic units) **Fee:** $2,246.65	**Benefit:** 75% = $1,685.00	85% = $2,185.15
+ 24128	22:31 HOURS TO 22:40 HOURS (132 basic units) **Fee:** $2,263.80	**Benefit:** 75% = $1,697.85	85% = $2,202.30
+ 24129	22:41 HOURS TO 22:50 HOURS (133 basic units) **Fee:** $2,280.95	**Benefit:** 75% = $1,710.75	85% = $2,219.45
+ 24130	22:51 HOURS TO 23:00 HOURS (134 basic units) **Fee:** $2,298.10	**Benefit:** 75% = $1,723.60	85% = $2,236.60
+ 24131	23:01 HOURS TO 23:10 HOURS (135 basic units) **Fee:** $2,315.25	**Benefit:** 75% = $1,736.45	85% = $2,253.75
+ 24132	23:11 HOURS TO 23:20 HOURS (136 basic units) **Fee:** $2,332.40	**Benefit:** 75% = $1,749.30	85% = $2,270.90
+ 24133	23:21 HOURS TO 23:30 HOURS (137 basic units) **Fee:** $2,349.55	**Benefit:** 75% = $1,762.20	85% = $2,288.05
+ 24134	23:31 HOURS TO 23:40 HOURS (138 basic units) **Fee:** $2,366.70	**Benefit:** 75% = $1,775.05	85% = $2,305.20
+ 24135	23:41 HOURS TO 23:50 HOURS (139 basic units) **Fee:** $2,383.85	**Benefit:** 75% = $1,787.90	85% = $2,322.35
+ 24136	23:51 HOURS TO 24:00 HOURS (140 basic units) **Fee:** $2,401.00	**Benefit:** 75% = $1,800.75	85% = $2,339.50
	SUBGROUP 22 - ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS		
25000	**ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA** (a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $17.15	**Benefit:** 75% = $12.90	85% = $14.60
25005	Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $34.30	**Benefit:** 75% = $25.75	85% = $29.20
25010	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $51.45	**Benefit:** 75% = $38.60	85% = $43.75
	SUBGROUP 23 - ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER		
25015	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** **-** where the patient is less than 12 months of age or 70 years or greater (1 basic units) **Fee:** $17.15	**Benefit:** 75% = $12.90	85% = $14.60
25020	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** - where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $34.30	**Benefit:** 75% = $25.75	85% = $29.20

	SUBGROUP 24 - ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER
25025	**EMERGENCY ANAESTHESIA** performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25030 or 25050 applies *(See para T10.3 of explanatory notes to this Category)* **Derived Fee:** An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item/s in the range 20100 - 21997 or 22900 plus, (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-25015, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050
25030	**ASSISTANCE AT AFTER HOURS EMERGENCY ANAESTHESIA** where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25050 applies *(See para T10.3 of explanatory notes to this Category)* **Derived Fee:** An additional amount of 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200 - 25205 plus, (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 2 (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050
	SUBGROUP 25 - PERFUSION AFTER HOURS EMERGENCY MODIFIER
25050	**AFTER HOURS EMERGENCY PERFUSION** where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies *(See para T10.3 of explanatory notes to this Category)* **Derived Fee:** An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015 plus, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 – 22050 and 22065 - 22075
	SUBGROUP 26 - ASSISTANCE AT ANAESTHESIA
25200	**ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA** on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (5 basic units) *(See para T10.9 of explanatory notes to this Category)* **Derived Fee:** An amount of $85.75 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable, an item in the range 25000 - 25020
25205	**ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA** where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; or (v) where the anaesthesia time exceeds 6 hours and the assistance is provided to the exclusion of all other patients (5 basic units) *(See para T10.9 of explanatory notes to this Category)* **Derived Fee:** An amount of $85.75 (5 basic units), plus an item in the range 23010 - 24136, plus, where applicable, an item in the range 25000 -25020

GROUP T8 - SURGICAL OPERATIONS

SUBGROUP 1 - GENERAL

30001	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds *(See para T8.9 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee which would have applied had the procedure not been discontinued
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $31.45 **Benefit:** 75% = $23.60 85% = $26.75
30006	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $40.25 **Benefit:** 75% = $30.20 85% = $34.25
30009 G 30010 S	LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) **Fee:** $52.55 **Benefit:** 75% = $39.45 **Fee:** $63.95 **Benefit:** 75% = $48.00
30013 G 30014 S	EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) **Fee:** $113.25 **Benefit:** 75% = $84.95 **Fee:** $134.50 **Benefit:** 75% = $100.90
30017	BURNS, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85
30020	BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) **Fee:** $549.55 **Benefit:** 75% = $412.20
I 30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85
H 30024	WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $45.20 **Benefit:** 75% = $33.90 85% = $38.45
30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $77.85 **Benefit:** 75% = $58.40 85% = $66.20
30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $71.40 **Benefit:** 75% = $53.55 85% = $60.70
30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $101.70 **Benefit:** 75% = $76.30 85% = $86.45

	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.10 of explanatory notes to this Category)*		
30038	**Fee:** $77.85	**Benefit:** 75% = $58.40	85% = $66.20
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.10 of explanatory notes to this Category)*		
30041 G	**Fee:** $124.65	**Benefit:** 75% = $93.50	85% = $106.00
30042 S	**Fee:** $160.70	**Benefit:** 75% = $120.55	85% = $136.60
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) *(See para T8.10 of explanatory notes to this Category)*		
30045	**Fee:** $101.70	**Benefit:** 75% = $76.30	85% = $86.45
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) *(See para T8.10 of explanatory notes to this Category)*		
30048 G	**Fee:** $129.60	**Benefit:** 75% = $97.20	85% = $110.20
30049 S	**Fee:** $160.70	**Benefit:** 75% = $120.55	85% = $136.60
	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)		
30052	**Fee:** $219.80	**Benefit:** 75% = $164.85	85% = $186.85
	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in this Group applies (Anaes.)		
30055	**Fee:** $63.95	**Benefit:** 75% = $48.00	85% = $54.40
	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.)		
30058	**Fee:** $124.65	**Benefit:** 75% = $93.50	85% = $106.00
	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.)		
30061	**Fee:** $20.30	**Benefit:** 75% = $15.25	85% = $17.30
	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)		
30064	**Fee:** $95.10	**Benefit:** 75% = $71.35	85% = $80.85
	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.)		
30067 G	**Fee:** $193.55	**Benefit:** 75% = $145.20	85% = $164.55
30068 S	**Fee:** $239.50	**Benefit:** 75% = $179.65	85% = $203.60
	DIAGNOSTIC BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)*		
30071	**Fee:** $45.20	**Benefit:** 75% = $33.90	85% = $38.45
	DIAGNOSTIC BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)*		
30074 G	**Fee:** $101.70	**Benefit:** 75% = $76.30	85% = $86.45
30075 S	**Fee:** $129.60	**Benefit:** 75% = $97.20	85% = $110.20
	DIAGNOSTIC DRILL BIOPSY OF LYMPH GLAND, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)*		
30078	**Fee:** $41.90	**Benefit:** 75% = $31.45	85% = $35.65
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)*		
30081	**Fee:** $95.10	**Benefit:** 75% = $71.35	85% = $80.85

	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach with a Jamshidi needle or similar device, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)*		
30084	**Fee:** $50.90	**Benefit:** 75% = $38.20	85% = $43.30
	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)*		
30087	**Fee:** $25.50	**Benefit:** 75% = $19.15	85% = $21.70
	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)*		
30090	**Fee:** $111.25	**Benefit:** 75% = $83.45	85% = $94.60
	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)*		
30093	**Fee:** $148.50	**Benefit:** 75% = $111.40	85% = $126.25
	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)*		
30094	**Fee:** $163.90	**Benefit:** 75% = $122.95	85% = $139.35
	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)*		
30096	**Fee:** $159.15	**Benefit:** 75% = $119.40	85% = $135.30
	SINUS, excision of, involving superficial tissue only (Anaes.)		
30099	**Fee:** $77.85	**Benefit:** 75% = $58.40	85% = $66.20
	SINUS, excision of, involving muscle and deep tissue (Anaes.)		
30102 G	**Fee:** $129.60	**Benefit:** 75% = $97.20	85% = $110.20
30103 S	**Fee:** $159.15	**Benefit:** 75% = $119.40	85% = $135.30
	PRE-AURICULAR SINUS, excision of (Anaes.)		
30104	**Fee:** $109.85	**Benefit:** 75% = $82.40	85% = $93.40
	GANGLION OR SMALL BURSA, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)		
30106 G	**Fee:** $134.50	**Benefit:** 75% = $100.90	85% = $114.35
30107 S	**Fee:** $190.35	**Benefit:** 75% = $142.80	85% = $161.80
	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.) (Assist.)		
30110 G	**Fee:** $246.10	**Benefit:** 75% = $184.60	85% = $209.20
30111 S	**Fee:** $321.55	**Benefit:** 75% = $241.20	85% = $273.35
	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.)		
30114	**Fee:** $321.55	**Benefit:** 75% = $241.20	
	LIPECTOMY transverse wedge excision of abdominal apron, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)*		
30165	**Fee:** $393.65	**Benefit:** 75% = $295.25	85% = $334.65
	LIPECTOMY wedge excision of skin or fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 1 EXCISION (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)*		
30168	**Fee:** $393.65	**Benefit:** 75% = $295.25	85% = $334.65
	LIPECTOMY wedge excision of skin or fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 2 OR MORE EXCISIONS (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)*		
30171	**Fee:** $598.75	**Benefit:** 75% = $449.10	85% = $537.25

30174	LIPECTOMY subumbilical excision with undermining of skin edges and strengthening of musculoaponeurotic wall, not being a service associated with items 45564 or 45565 or 45530 (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $598.75 **Benefit:** 75% = $449.10 85% = $537.25
30177	LIPECTOMY radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $853.15 **Benefit:** 75% = $639.90
30178	CLOSURE OF ABDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, being a service associated with items 45564, 45565 or 45530 (Anaes.) (Assist.) **Fee:** $598.75 **Benefit:** 75% = $449.10
30180	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.) **Fee:** $118.10 **Benefit:** 75% = $88.60 85% = $100.40
30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.) **Fee:** $213.30 **Benefit:** 75% = $160.00 85% = $181.35
30185	PALMAR OR PLANTAR WARTS (10 or more), definitive removal of, excluding ablative methods alone, not being a service to which item 30186 or 30187 applies (Anaes.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $157.95 **Benefit:** 75% = $118.50 85% = $134.30
30186	PALMAR OR PLANTAR WARTS (less than 10), definitive removal of, excluding ablative methods alone, not being a service to which item 30185 or 30187 applies (Anaes.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $41.10 **Benefit:** 75% = $30.85 85% = $34.95
30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital or day-hospital facility, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $222.40 **Benefit:** 75% = $166.80 85% = $189.05
30189	WARTS or MOLLUSCUM CONTAGIOSUM (one or more), removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in this Group applies (Anaes.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $127.45 **Benefit:** 75% = $95.60 85% = $108.35
30190	ANGIOFIBROMAS, TRICHOEPITHELIOMAS or other severely disfiguring tumours suitable for laser excision as confirmed by specialist opinion, of the face or neck, removal of, by carbon dioxide laser or erbium laser excision-ablation including associated resurfacing (10 or more tumours) (Anaes.) (Assist.) **Fee:** $344.25 **Benefit:** 75% = $258.20 85% = $292.65
30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $34.30 **Benefit:** 75% = $25.75 85% = $29.20
30195	BENIGN NEOPLASM OF SKIN, other than viral verrucae (common warts) seborrheic keratoses, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (1 or more lesions) (Anaes.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $54.95 **Benefit:** 75% = $41.25 85% = $46.75
30196	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes.) *(See para T8.14 of explanatory notes to this Category)* **Fee:** $109.30 **Benefit:** 75% = $82.00 85% = $92.95

30197	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 OR MORE LESIONS) (Anaes.) *(See para T8.14 of explanatory notes to this Category)* **Fee:** $380.85 **Benefit:** 75% = $285.65 85% = $323.75
30202	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles, not being a service to which item 30203 applies *(See para T8.14 of explanatory notes to this Category)* **Fee:** $41.80 **Benefit:** 75% = $31.35 85% = $35.55
30203	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles (10 OR MORE LESIONS) *(See para T8.14 of explanatory notes to this Category)* **Fee:** $147.35 **Benefit:** 75% = $110.55 85% = $125.25
30205	MALIGNANT NEOPLASM OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE THE MALIGNANT NEOPLASM EXTENDS INTO CARTILAGE (Anaes.) **Fee:** $109.30 **Benefit:** 75% = $82.00 85% = $92.95
30207	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (Anaes.) **Fee:** $38.60 **Benefit:** 75% = $28.95 85% = $32.85
30210	KELOID and other SKIN LESIONS, EXTENSIVE, MULTIPLE INJECTIONS OF HYDROCORTISONE or similar preparations where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $141.05 **Benefit:** 75% = $105.80 85% = $119.90
30213	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes.) *(See para T8.15 of explanatory notes to this Category)* **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
30214	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - session of at least 20 minutes duration ***- where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** *(See para T8.15 of explanatory notes to this Category)* **Fee:** $95.00 **Benefit:** 75% = $71.25
30216	HAEMATOMA, aspiration of (Anaes.) **Fee:** $23.65 **Benefit:** 75% = $17.75 85% = $20.15
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital or day-hospital facility - INCISION WITH DRAINAGE OF (excluding aftercare) **Fee:** $23.65 **Benefit:** 75% = $17.75 85% = $20.15
30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) **Fee:** $141.05 **Benefit:** 75% = $105.80
30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $205.65 **Benefit:** 75% = $154.25 85% = $174.85
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $231.65 **Benefit:** 75% = $173.75 85% = $196.95
30226	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.) **Fee:** $129.60 **Benefit:** 75% = $97.20 85% = $110.20
30229	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20 85% = $200.85
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $193.55 **Benefit:** 75% = $145.20 85% = $164.55

30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $255.90 **Benefit:** 75% = $191.95 85% = $217.55
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) **Fee:** $129.60 **Benefit:** 75% = $97.20 85% = $110.20
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.) **Fee:** $639.85 **Benefit:** 75% = $479.90
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,082.75 **Benefit:** 75% = $812.10
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,663.15 **Benefit:** 75% = $1,247.40 85% = $1,601.65
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.) **Fee:** $721.90 **Benefit:** 75% = $541.45
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $961.25 **Benefit:** 75% = $720.95
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) **Fee:** $385.50 **Benefit:** 75% = $289.15
30259	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $170.60 **Benefit:** 75% = $127.95 85% = $145.05
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $50.90 **Benefit:** 75% = $38.20 85% = $43.30
30265 G 30266 S	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) **Fee:** $101.70 **Benefit:** 75% = $76.30 85% = $86.45 **Fee:** $129.60 **Benefit:** 75% = $97.20 85% = $110.20
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $129.60 **Benefit:** 75% = $97.20 85% = $110.20
30272	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $255.90 **Benefit:** 75% = $191.95 85% = $217.55
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commandotype operation) (Anaes.) (Assist.) **Fee:** $1,525.65 **Benefit:** 75% = $1,144.25
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes.) **Fee:** $40.25 **Benefit:** 75% = $30.20 85% = $34.25
30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.) **Fee:** $103.40 **Benefit:** 75% = $77.55 85% = $87.90
30282 G 30283 S	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $134.50 **Benefit:** 75% = $100.90 85% = $114.35 **Fee:** $177.15 **Benefit:** 75% = $132.90 85% = $150.60
30286	BRANCHIAL CYST, removal of (Anaes.) (Assist.) **Fee:** $344.35 **Benefit:** 75% = $258.30 85% = $292.70

30289	BRANCHIAL FISTULA, removal of (Anaes.) (Assist.) **Fee:** $434.70 **Benefit:** 75% = $326.05
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.) **Fee:** $385.50 **Benefit:** 75% = $289.15 85% = $327.70
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) **Fee:** $1,525.65 **Benefit:** 75% = $1,144.25
30296	THYROIDECTOMY, total (Anaes.) (Assist.) **Fee:** $886.00 **Benefit:** 75% = $664.50
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) **Fee:** $886.00 **Benefit:** 75% = $664.50
H 30299	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $551.65 **Benefit:** 75% = $413.75
H 30300	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Anaes.) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $662.05 **Benefit:** 75% = $496.55
H 30302	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Anaes.) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $441.35 **Benefit:** 75% = $331.05
H 30303	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Anaes.) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $529.60 **Benefit:** 75% = $397.20
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) **Fee:** $691.20 **Benefit:** 75% = $518.40
30308	BILATERAL SUBTOTAL THYROIDECTOMY (Anaes.) (Assist.) **Fee:** $691.20 **Benefit:** 75% = $518.40
30309	THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (Anaes.) (Assist.) **Fee:** $886.00 **Benefit:** 75% = $664.50
30310	THYROID, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Anaes.) (Assist.) **Fee:** $395.85 **Benefit:** 75% = $296.90
30313	THYROGLOSSAL CYST, removal of (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20 85% = $200.85
30314	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) **Fee:** $395.85 **Benefit:** 75% = $296.90
30315	PARATHYROID operation for hyperparathyroidism (Anaes.) (Assist.) **Fee:** $986.55 **Benefit:** 75% = $739.95
30317	CERVICAL REEXPLORATION for recurrent or persistent hyperparathyroidism (Anaes.) (Assist.) **Fee:** $1,181.30 **Benefit:** 75% = $886.00
30318	MEDIASTINUM, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) **Fee:** $785.50 **Benefit:** 75% = $589.15

30320	MEDIASTINUM, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) **Fee:** $1,181.30 **Benefit:** 75% = $886.00
30321	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of (Anaes.) (Assist.) **Fee:** $785.50 **Benefit:** 75% = $589.15
30323	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of, requiring complex and extensive dissection (Anaes.) (Assist.) **Fee:** $1,181.30 **Benefit:** 75% = $886.00
30324	ADRENAL GLAND TUMOUR, excision of (Anaes.) (Assist.) **Fee:** $1,181.30 **Benefit:** 75% = $886.00
30329	LYMPH GLANDS of GROIN, limited excision of (Anaes.) **Fee:** $213.70 **Benefit:** 75% = $160.30 85% = $181.65
30330	LYMPH GLANDS of GROIN, radical excision of (Anaes.) (Assist.) **Fee:** $622.05 **Benefit:** 75% = $466.55
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.) **Fee:** $300.15 **Benefit:** 75% = $225.15
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $750.25 **Benefit:** 75% = $562.70
30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $900.35 **Benefit:** 75% = $675.30
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $418.25 **Benefit:** 75% = $313.70
30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.) *(See para T8.18 of explanatory notes to this Category)* **Fee:** $451.10 **Benefit:** 75% = $338.35
30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
30378	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours (Anaes.) (Assist.) **Fee:** $453.20 **Benefit:** 75% = $339.90
30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.) **Fee:** $803.30 **Benefit:** 75% = $602.50
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.) **Fee:** $1,131.10 **Benefit:** 75% = $848.35
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.) **Fee:** $951.50 **Benefit:** 75% = $713.65
30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $487.50 **Benefit:** 75% = $365.65
30387	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $549.55 **Benefit:** 75% = $412.20

30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.) **Fee:** $1,382.55 **Benefit:** 75% = $1,036.95
30390	LAPAROSCOPY, diagnostic (Anaes.) **Fee:** $190.35 **Benefit:** 75% = $142.80
30391	LAPAROSCOPY with biopsy (Anaes.) (Assist.) **Fee:** $246.10 **Benefit:** 75% = $184.60
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) **Fee:** $583.75 **Benefit:** 75% = $437.85
30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) **Fee:** $453.20 **Benefit:** 75% = $339.90
30394	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Anaes.) (Assist.) **Fee:** $426.50 **Benefit:** 75% = $319.90
30396	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision, with or without closure of abdomen and with or without mesh or zipper insertion (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $879.80 **Benefit:** 75% = $659.85
30397	LAPAROSTOMY, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Anaes.) **Fee:** $201.10 **Benefit:** 75% = $150.85
30399	LAPAROSTOMY, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Anaes.) (Assist.) **Fee:** $276.60 **Benefit:** 75% = $207.45
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) **Fee:** $547.40 **Benefit:** 75% = $410.55
30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.) **Fee:** $402.10 **Benefit:** 75% = $301.60
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
30405	VENTRAL OR INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.) **Fee:** $791.85 **Benefit:** 75% = $593.90
30406	PARACENTESIS ABDOMINIS (Anaes.) **Fee:** $45.20 **Benefit:** 75% = $33.90 85% = $38.45
30408	PERITONEO venous (Leveen) shunt, insertion of (Anaes.) (Assist.) **Fee:** $339.35 **Benefit:** 75% = $254.55
30409	LIVER BIOPSY, percutaneous (Anaes.) **Fee:** $151.05 **Benefit:** 75% = $113.30 85% = $128.40
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) **Fee:** $76.85 **Benefit:** 75% = $57.65
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) **Fee:** $45.30 **Benefit:** 75% = $34.00 85% = $38.55
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75

30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,194.00 **Benefit:** 75% = $895.50
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $648.25 **Benefit:** 75% = $486.20
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $972.30 **Benefit:** 75% = $729.25
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,382.55 **Benefit:** 75% = $1,036.95
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:** $707.20 **Benefit:** 75% = $530.40 85% = $645.70
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,728.00 **Benefit:** 75% = $1,296.00
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) **Fee:** $584.45 **Benefit:** 75% = $438.35
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) **Fee:** $1,131.10 **Benefit:** 75% = $848.35
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) **Fee:** $1,351.00 **Benefit:** 75% = $1,013.25
30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.) **Fee:** $1,445.30 **Benefit:** 75% = $1,084.00 85% = $1,383.80
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.) **Fee:** $2,010.80 **Benefit:** 75% = $1,508.10 85% = $1,949.30
30431	LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $389.60
30433	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.) **Fee:** $628.35 **Benefit:** 75% = $471.30
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.) **Fee:** $509.05 **Benefit:** 75% = $381.80
30436	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes.) (Assist.) **Fee:** $565.55 **Benefit:** 75% = $424.20
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.) **Fee:** $703.85 **Benefit:** 75% = $527.90
30438	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.) **Fee:** $996.05 **Benefit:** 75% = $747.05 85% = $934.55
30439	OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes.) (Assist.) **Fee:** $160.70 **Benefit:** 75% = $120.55
30440	CHOLANGIOGRAM, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30451 applies (Anaes.) (Assist.) **Fee:** $455.55 **Benefit:** 75% = $341.70 85% = $394.05
30441	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.) **Fee:** $117.90 **Benefit:** 75% = $88.45
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.) **Fee:** $160.70 **Benefit:** 75% = $120.55

30443	CHOLECYSTECTOMY (Anaes.) (Assist.) **Fee:** $639.85 **Benefit:** 75% = $479.90
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.) **Fee:** $639.85 **Benefit:** 75% = $479.90
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.) **Fee:** $639.85 **Benefit:** 75% = $479.90
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.) **Fee:** $842.05 **Benefit:** 75% = $631.55
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.) **Fee:** $936.35 **Benefit:** 75% = $702.30
30450	CALCULUS OF BILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627, 36630, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $453.80 **Benefit:** 75% = $340.35 85% = $392.30
30451	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.) **Fee:** $231.65 **Benefit:** 75% = $173.75 85% = $196.95
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) **Fee:** $326.75 **Benefit:** 75% = $245.10
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.) **Fee:** $746.45 **Benefit:** 75% = $559.85
30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.) **Fee:** $877.65 **Benefit:** 75% = $658.25
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.) **Fee:** $1,194.00 **Benefit:** 75% = $895.50 85% = $1,132.50
30458	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.) **Fee:** $877.65 **Benefit:** 75% = $658.25
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) **Fee:** $746.45 **Benefit:** 75% = $559.85
30461	RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.) (Assist.) **Fee:** $1,279.55 **Benefit:** 75% = $959.70
30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $1,570.95 **Benefit:** 75% = $1,178.25
30464	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Anaes.) (Assist.) **Fee:** $1,885.20 **Benefit:** 75% = $1,413.90
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,087.10 **Benefit:** 75% = $815.35
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,344.70 **Benefit:** 75% = $1,008.55
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) **Fee:** $1,489.35 **Benefit:** 75% = $1,117.05 85% = $1,427.85

30472	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes.) (Assist.) **Fee:** $804.30 **Benefit:** 75% = $603.25 85% = $742.80
30473	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30476 or 30478 applies (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $153.30 **Benefit:** 75% = $115.00 85% = $130.35
30475	ENDOSCOPY with balloon dilatation of gastric or gastroduodenal stricture (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $277.20 **Benefit:** 75% = $207.90 85% = $235.65
30476	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with endoscopic sclerosing injection or banding of oesophageal or gastric varices, not being a service associated with a service to which item 30473 or 30478 applies (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $212.55 **Benefit:** 75% = $159.45 85% = $180.70
30478	OESOPHAGOSCOPY (not being a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with 1 or more of the following endoscopic procedures - polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastrointestinal lesions, not being a service associated with a service to which item 30473 or 30476 applies (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $212.55 **Benefit:** 75% = $159.45 85% = $180.70
30479	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions or strictures of the gastrointestinal tract (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $412.05 **Benefit:** 75% = $309.05 85% = $350.55
30481	PERCUTANEOUS GASTROSTOMY (initial procedure), including any associated imaging services (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $309.00 **Benefit:** 75% = $231.75 85% = $262.65
30482	PERCUTANEOUS GASTROSTOMY (repeat procedure), including any associated imaging services (Anaes.) **Fee:** $219.70 **Benefit:** 75% = $164.80 85% = $186.75
30483	GASTROSTOMY BUTTON, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes.) **Fee:** $153.25 **Benefit:** 75% = $114.95 85% = $130.30
30484	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $315.80 **Benefit:** 75% = $236.85 85% = $268.45
30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $487.50 **Benefit:** 75% = $365.65 85% = $426.00
30487	SMALL BOWEL INTUBATION with biopsy (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $156.55 **Benefit:** 75% = $117.45 85% = $133.10
30488	SMALL BOWEL INTUBATION as an independent procedure (Anaes.) **Fee:** $77.85 **Benefit:** 75% = $58.40 85% = $66.20
30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $455.55 **Benefit:** 75% = $341.70 85% = $394.05
30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $480.60 **Benefit:** 75% = $360.45 85% = $419.10
30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $681.35 **Benefit:** 75% = $511.05

30493	BILIARY MANOMETRY (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $288.40 **Benefit:** 75% = $216.30 85% = $245.15
30494	ENDOSCOPIC BILIARY DILATATION (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $363.90 **Benefit:** 75% = $272.95
30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $681.35 **Benefit:** 75% = $511.05
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.) **Fee:** $509.05 **Benefit:** 75% = $381.80 85% = $447.55
30497	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.) **Fee:** $606.90 **Benefit:** 75% = $455.20
30499	VAGOTOMY, highly selective (Anaes.) (Assist.) **Fee:** $721.90 **Benefit:** 75% = $541.45
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.) **Fee:** $772.90 **Benefit:** 75% = $579.70 85% = $711.40
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.) **Fee:** $853.15 **Benefit:** 75% = $639.90
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.) **Fee:** $955.25 **Benefit:** 75% = $716.45 85% = $893.75
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.) **Fee:** $477.55 **Benefit:** 75% = $358.20
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.) **Fee:** $835.85 **Benefit:** 75% = $626.90
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.) **Fee:** $879.80 **Benefit:** 75% = $659.85
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.) **Fee:** $879.80 **Benefit:** 75% = $659.85 85% = $818.30
30511	(*see Item 31441 for repair, revision or replacement of implanted reservoir associated with adjustable gastric band*) (*see Item 14215 for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band*) MORBID OBESITY, gastric reduction or gastroplasty for, by any method (Anaes.) (Assist.) **Fee:** $735.25 **Benefit:** 75% = $551.45
30512	MORBID OBESITY, gastric bypass for, by any method including anastomosis (Anaes.) (Assist.) **Fee:** $904.80 **Benefit:** 75% = $678.60
30514	MORBID OBESITY, surgical reversal, by any method, of procedure to which item 30511 or 30512 applies (Anaes.) (Assist.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $1,332.10 **Benefit:** 75% = $999.10
30515	GASTROENTEROSTOMY (INCLUDING GASTRODUODENOSTOMY) OR ENTEROCOLOSTOMY OR ENTEROENTEROSTOMY (Anaes.) (Assist.) **Fee:** $609.55 **Benefit:** 75% = $457.20
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.) **Fee:** $798.10 **Benefit:** 75% = $598.60
30518	PARTIAL GASTRECTOMY (Anaes.) (Assist.) **Fee:** $854.65 **Benefit:** 75% = $641.00

30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.) **Fee:** $584.45 **Benefit:** 75% = $438.35
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) **Fee:** $1,250.50 **Benefit:** 75% = $937.90
30523	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $1,306.95 **Benefit:** 75% = $980.25
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.) **Fee:** $1,438.95 **Benefit:** 75% = $1,079.25
30526	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.) **Fee:** $1,866.25 **Benefit:** 75% = $1,399.70
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.) *(See para T8.23 of explanatory notes to this Category)* **Fee:** $754.10 **Benefit:** 75% = $565.60
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.) *(See para T8.23 of explanatory notes to this Category)* **Fee:** $1,131.10 **Benefit:** 75% = $848.35
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) *(See para T8.23 of explanatory notes to this Category)* **Fee:** $678.70 **Benefit:** 75% = $509.05
30532	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) *(See para T8.23 of explanatory notes to this Category)* **Fee:** $779.30 **Benefit:** 75% = $584.50
30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) *(See para T8.23 of explanatory notes to this Category)* **Fee:** $927.00 **Benefit:** 75% = $695.25
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.) **Fee:** $1,468.35 **Benefit:** 75% = $1,101.30
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,489.35 **Benefit:** 75% = $1,117.05
30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,030.60 **Benefit:** 75% = $772.95
30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) **Fee:** $754.10 **Benefit:** 75% = $565.60
30541	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,313.35 **Benefit:** 75% = $985.05
30542	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $892.30 **Benefit:** 75% = $669.25
30544	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.) **Fee:** $653.55 **Benefit:** 75% = $490.20

30545	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,589.95 **Benefit:** 75% = $1,192.50
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,093.40 **Benefit:** 75% = $820.05 85% = $1,031.90
30548	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) **Fee:** $816.85 **Benefit:** 75% = $612.65 85% = $755.35
30550	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,784.70 **Benefit:** 75% = $1,338.55
30551	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,231.70 **Benefit:** 75% = $923.80
30553	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) **Fee:** $911.05 **Benefit:** 75% = $683.30 85% = $849.55
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,985.75 **Benefit:** 75% = $1,489.35
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,369.85 **Benefit:** 75% = $1,027.40
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,011.70 **Benefit:** 75% = $758.80
30559	OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.) **Fee:** $735.25 **Benefit:** 75% = $551.45 85% = $673.75
30560	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.) **Fee:** $816.85 **Benefit:** 75% = $612.65
30562	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel (Anaes.) (Assist.) **Fee:** $515.00 **Benefit:** 75% = $386.25
30563	COLOSTOMY OR ILEOSTOMY, refashioning of (Anaes.) (Assist.) **Fee:** $515.00 **Benefit:** 75% = $386.25 85% = $453.50
30564	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.) **Fee:** $668.40 **Benefit:** 75% = $501.30
30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) **Fee:** $754.10 **Benefit:** 75% = $565.60
30566	SMALL INTESTINE, resection of, with anastomosis (Anaes.) (Assist.) **Fee:** $837.70 **Benefit:** 75% = $628.30
30568	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.) (Assist.) **Fee:** $628.35 **Benefit:** 75% = $471.30
30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.) (Assist.) **Fee:** $320.40 **Benefit:** 75% = $240.30
30571	APPENDICECTOMY, not being a service to which item 30574 applies (Anaes.) (Assist.) **Fee:** $385.50 **Benefit:** 75% = $289.15
30572	LAPAROSCOPIC APPENDICECTOMY (Anaes.) (Assist.) **Fee:** $385.50 **Benefit:** 75% = $289.15

30574	**NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item* APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.) **Fee:** $106.70 **Benefit:** 75% = $80.05
30575	PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.) (Assist.) **Fee:** $443.80 **Benefit:** 75% = $332.85
30577	PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.) **Fee:** $942.65 **Benefit:** 75% = $707.00
30578	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.) **Fee:** $992.85 **Benefit:** 75% = $744.65
30580	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.) **Fee:** $904.80 **Benefit:** 75% = $678.60
30581	ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.) (Assist.) **Fee:** $659.85 **Benefit:** 75% = $494.90
30583	DISTAL PANCREATECTOMY (Anaes.) (Assist.) **Fee:** $1,033.60 **Benefit:** 75% = $775.20
30584	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.) **Fee:** $1,525.65 **Benefit:** 75% = $1,144.25
30586	PANCREATIC CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic means (Anaes.) (Assist.) **Fee:** $606.90 **Benefit:** 75% = $455.20
30587	PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.) **Fee:** $628.35 **Benefit:** 75% = $471.30
30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.) **Fee:** $1,082.75 **Benefit:** 75% = $812.10
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.) **Fee:** $1,194.00 **Benefit:** 75% = $895.50
30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.) **Fee:** $1,633.85 **Benefit:** 75% = $1,225.40 85% = $1,572.35
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.) **Fee:** $1,885.20 **Benefit:** 75% = $1,413.90
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.) **Fee:** $776.60 **Benefit:** 75% = $582.45
30597	SPLENECTOMY (Anaes.) (Assist.) **Fee:** $623.30 **Benefit:** 75% = $467.50
30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.) **Fee:** $1,131.10 **Benefit:** 75% = $848.35
30600	DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.) **Fee:** $672.60 **Benefit:** 75% = $504.45
30601	DIAPHRAGMATIC HERNIA, CONGENITAL repair of, by thoracic or abdominal approach (Anaes.) (Assist.) **Fee:** $828.50 **Benefit:** 75% = $621.40
30602	PORTAL HYPERTENSION, porto-caval shunt for (Anaes.) (Assist.) **Fee:** $1,344.70 **Benefit:** 75% = $1,008.55
30603	PORTAL HYPERTENSION, meso-caval shunt for (Anaes.) (Assist.) **Fee:** $1,420.20 **Benefit:** 75% = $1,065.15 85% = $1,358.70

30605	PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes.) (Assist.) **Fee:** $1,614.95 **Benefit:** 75% = $1,211.25
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) **Fee:** $961.40 **Benefit:** 75% = $721.05
30609	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (Anaes.) (Assist.) **Fee:** $402.00 **Benefit:** 75% = $301.50
30612 G 30614 S	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30 **Fee:** $402.00 **Benefit:** 75% = $301.50
30615	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
30616 G 30617 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person under 10 years of age (Anaes.) **Fee:** $229.65 **Benefit:** 75% = $172.25 **Fee:** $308.40 **Benefit:** 75% = $231.30
30620 G 30621 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $259.20 **Benefit:** 75% = $194.40 **Fee:** $352.70 **Benefit:** 75% = $264.55
30628	HYDROCELE, tapping of **Fee:** $30.80 **Benefit:** 75% = $23.10 85% = $26.20
30631	HYDROCELE, removal of, not being a service associated with a service to which items 30638, 30641 and 30644 apply (Anaes.) **Fee:** $204.80 **Benefit:** 75% = $153.60 85% = $174.10
30634 G 30635 S	VARICOCELE, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (Anaes.) (Assist.) **Fee:** $203.45 **Benefit:** 75% = $152.60 **Fee:** $252.60 **Benefit:** 75% = $189.45
30638 G 30641 S	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.) **Fee:** $259.20 **Benefit:** 75% = $194.40 **Fee:** $352.70 **Benefit:** 75% = $264.55
30644	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
30653	CIRCUMCISION of a male UNDER 6 MONTHS of age (Anaes.) **Fee:** $40.25 **Benefit:** 75% = $30.20 85% = $34.25
30656	CIRCUMCISION of a male UNDER 10 YEARS of age but not less than 6 months of age (Anaes.) **Fee:** $93.60 **Benefit:** 75% = $70.20 85% = $79.60
30659 G 30660 S	CIRCUMCISION of a male 10 YEARS OF AGE OR OVER (Anaes.) **Fee:** $129.60 **Benefit:** 75% = $97.20 85% = $110.20 **Fee:** $160.70 **Benefit:** 75% = $120.55 85% = $136.60
30663	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia (Anaes.) **Fee:** $124.95 **Benefit:** 75% = $93.75 85% = $106.25
30666	PARAPHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $41.10 **Benefit:** 75% = $30.85 85% = $34.95
30672	COCCYX, excision of (Anaes.) (Assist.) **Fee:** $385.50 **Benefit:** 75% = $289.15

	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.)		
30675 G	**Fee:** $259.20	**Benefit:** 75% = $194.40	85% = $220.35
30676 S	**Fee:** $328.10	**Benefit:** 75% = $246.10	85% = $278.90
	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.)		
30679	**Fee:** $83.35	**Benefit:** 75% = $62.55	85% = $70.85
	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 6 or fewer sections (Anaes.)		
31000	**Fee:** $502.70	**Benefit:** 75% = $377.05	85% = $441.20
	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 7 to 12 sections (inclusive) (Anaes.)		
31001	**Fee:** $628.35	**Benefit:** 75% = $471.30	85% = $566.85
	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 13 or more sections (Anaes.)		
31002	**Fee:** $754.10	**Benefit:** 75% = $565.60	85% = $692.60
	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 T8.24 of explanatory notes to this Category)*		
31200	**Fee:** $29.45	**Benefit:** 75% = $22.10	85% = $25.05
	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter**, **removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.24 of explanatory notes to this Category)*		
I 31205	**Fee:** $82.55	**Benefit:** 75% = $61.95	85% = $70.20
	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 10mm and up to and including 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.24 of explanatory notes to this Category)*		
I 31210	**Fee:** $106.55	**Benefit:** 75% = $79.95	85% = $90.60
	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.24 of explanatory notes to this Category)*		
31215	**Fee:** $124.20	**Benefit:** 75% = $93.15	85% = $105.60
	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter, removal of 4 to 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimens excised are sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.24 of explanatory notes to this Category)*		
I 31220	**Fee:** $185.70	**Benefit:** 75% = $139.30	85% = $157.85

I 31225	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter, removal of more than 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimens excised are sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $330.00 **Benefit:** 75% = $247.50 85% = $280.50
31230	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from nose, eyelid, lip, ear, digit or genitalia,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $145.45 **Benefit:** 75% = $109.10 85% = $123.65
I 31235	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size up to and including 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $124.20 **Benefit:** 75% = $93.15 85% = $105.60
31240	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size more than 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $145.45 **Benefit:** 75% = $109.10 85% = $123.65
31245	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HYDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $319.35 **Benefit:** 75% = $239.55 85% = $271.45
31250	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface ***where the specimen excised is sent for histological confirmation of diagnosis*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $319.35 **Benefit:** 75% = $239.55 85% = $271.45
31255	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter -** where removal is by therapeutic **surgical excision (other than by shave excision) and suture and** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $191.60 **Benefit:** 75% = $143.70 85% = $162.90
31256	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $191.60 **Benefit:** 75% = $143.70 85% = $162.90
31257	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where** ***the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $191.60 **Benefit:** 75% = $143.70 85% = $162.90

	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where** ***the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.24 of explanatory notes to this Category)*		
31258	**Fee:** $191.60	**Benefit:** 75% = $143.70	85% = $162.90
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **therapeutic surgical excision (other than shave excision) and suture** ***and where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)*		
31260	**Fee:** $273.20	**Benefit:** 75% = $204.90	85% = $232.25
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)*		
31261	**Fee:** $273.20	**Benefit:** 75% = $204.90	85% = $232.25
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the original tumour size was more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)*		
31262	**Fee:** $273.20	**Benefit:** 75% = $204.90	85% = $232.25
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.24 of explanatory notes to this Category)*		
31263	**Fee:** $273.20	**Benefit:** 75% = $204.90	85% = $232.25
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)*		
31265	**Fee:** $159.65	**Benefit:** 75% = $119.75	85% = $135.75
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)*		
31266	**Fee:** $159.65	**Benefit:** 75% = $119.75	85% = $135.75
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)*		
31267	**Fee:** $159.65	**Benefit:** 75% = $119.75	85% = $135.75

31268	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $159.65 **Benefit:** 75% = $119.75 85% = $135.75
31270	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $223.55 **Benefit:** 75% = $167.70 85% = $190.05
31271	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $223.55 **Benefit:** 75% = $167.70 85% = $190.05
31272	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $223.55 **Benefit:** 75% = $167.70 85% = $190.05
31273	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $223.55 **Benefit:** 75% = $167.70 85% = $190.05
31275	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $259.00 **Benefit:** 75% = $194.25 85% = $220.15
31276	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $259.00 **Benefit:** 75% = $194.25 85% = $220.15
31277	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $259.00 **Benefit:** 75% = $194.25 85% = $220.15

31278	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $259.00 **Benefit:** 75% = $194.25 85% = $220.15
31280	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items** ***31255*** **and** ***31265,*** **tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $134.85 **Benefit:** 75% = $101.15 85% = $114.65
31281	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items** ***31255*** **and** ***31265*****,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $135.40 **Benefit:** 75% = $101.55 85% = $115.10
31282	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items** ***31255*** **and** ***31265*****,** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $135.40 **Benefit:** 75% = $101.55 85% = $115.10
31283	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items** ***31255*** **and** ***31265*****,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment*****,** **where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $135.40 **Benefit:** 75% = $101.55 85% = $115.10
31285	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items** ***31260*** **and** ***31270*****, tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $184.35 **Benefit:** 75% = $138.30 85% = $156.70
31286	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $184.35 **Benefit:** 75% = $138.30 85% = $156.70
31287	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270,** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $184.35 **Benefit:** 75% = $138.30 85% = $156.70

31288	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31270,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment*****,** **where the tumour size is more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $184.35 **Benefit:** 75% = $138.30 85% = $156.70
31290	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items** ***31260*** **and** ***31275***, **tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $212.80 **Benefit:** 75% = $159.60 85% = $180.90
31291	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $212.80 **Benefit:** 75% = $159.60 85% = $180.90
31292	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275,** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $212.80 **Benefit:** 75% = $159.60 85% = $180.90
31293	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31275,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $212.80 **Benefit:** 75% = $159.60 85% = $180.90
31295	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT (where lesion was treated by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy), ***performed by a specialist in the practice of his or her specialty or by a practitioner other than the practitioner who provided the previous treatment***, **removal from the head or neck (anterior to the sternomastoid muscles)**, where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $253.45 **Benefit:** 75% = $190.10 85% = $215.45
I 31300	**TREATMENT OF MALIGNANT MELANOMA AND LOCALLY AGGRESSIVE SKIN TUMOURS** Definitive surgical excision for items 31300-31335 is defined as "surgical removal with an adequate margin and as a result, no further surgery is indicated at the site of the primary tumour". MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in para T8.21.7 of the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $276.90 **Benefit:** 75% = $207.70 85% = $235.40
31305	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE and **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in para T8.21.7 of the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $340.60 **Benefit:** 75% = $255.45 85% = $289.55

	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above in para T8.21.7 of the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)
I	*(See para T8.24 and T8.25 of explanatory notes to this Category)*
31310	**Fee:** $241.20 **Benefit:** 75% = $180.90 85% = $205.05
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by **definitive surgical excision (as defined above in para T8.21.7 of the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)
I	*(See para T8.24 and T8.25 of explanatory notes to this Category)*
31315	**Fee:** $305.10 **Benefit:** 75% = $228.85 85% = $259.35
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 20mm in diameter** and where removal is by **definitive surgical excision (as defined above in para T8.21.7 of the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)
31320	*(See para T8.24 and T8.25 of explanatory notes to this Category)* **Fee:** $340.60 **Benefit:** 75% = $255.45 85% = $289.55
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31300* and *31310* - tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in para T8.21.7 of the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)
I	*(See para T8.24 of explanatory notes to this Category)*
31325	**Fee:** $234.20 **Benefit:** 75% = $175.65 85% = $199.10
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31310* - tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in para T8.21.7 of the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)
I	*(See para T8.24 of explanatory notes to this Category)*
31330	**Fee:** $276.90 **Benefit:** 75% = $207.70 85% = $235.40
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31320* - tumour size more than 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in para T8.21.7 of the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)
	(See para T8.24 of explanatory notes to this Category)
31335	**Fee:** $319.35 **Benefit:** 75% = $239.55 85% = $271.45
	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, 31256, 31257, 31258, 31260, 31261, 31262, 31263, 31265, 31266, 31267, 31268, 31270, 31271, 31272, 31273, 31275, 31276, 31277, 31278, 31280, 31281, 31282, 31283, 31285, 31286, 31287, 31288, 31290, 31291, 31292, 31293, 31295, 31300, 31305, 31310, 31315, 31320, 31325, 31330 or 31335** (Anaes.)
I	*(See para T8.24 of explanatory notes to this Category)*
31340	**Derived Fee:** 75% of the fee for excision of malignant tumour
	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and **50mm or more in diameter**, or is sub-fascial, ***where the specimen is sent for histological confirmation of diagnosis*** (Anaes.)
I	*(See para T8.24 of explanatory notes to this Category)*
31345	**Fee:** $182.50 **Benefit:** 75% = $136.90 85% = $155.15
	LIPOSUCTION (suction assisted lipolysis) to 1 regional area for treatment of contour problems of abdominal or upper arm or thigh fat due to repeated insulin injections, ***where the lesion is subcutaneous and 50mm or more in diameter*** (Anaes.)
I	
31346	**Fee:** $182.50 **Benefit:** 75% = $136.90 85% = $155.15

I 31350	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by **surgical excision**, ***where the specimen excised is sent for histological confirmation of diagnosis***, not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $375.05 **Benefit:** 75% = $281.30 85% = $318.80
I 31355	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by **surgical excision**, where ***histological proof of malignancy has been obtained***, not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $618.30 **Benefit:** 75% = $463.75 85% = $556.80
I 31400	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $225.95 **Benefit:** 75% = $169.50 85% = $192.10
I 31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $260.75 **Benefit:** 75% = $195.60
31406	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $434.60 **Benefit:** 75% = $325.95 85% = $373.10
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,350.25 **Benefit:** 75% = $1,012.70
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,663.15 **Benefit:** 75% = $1,247.40
31420	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $159.15 **Benefit:** 75% = $119.40 85% = $135.30
31423	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $347.65 **Benefit:** 75% = $260.75 85% = $295.55
31426	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $695.40 **Benefit:** 75% = $521.55
31429	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $1,083.65 **Benefit:** 75% = $812.75
31432	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $1,159.00 **Benefit:** 75% = $869.25
31435	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $851.85 **Benefit:** 75% = $638.90
31438	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $1,350.25 **Benefit:** 75% = $1,012.70
31441	(*see Item 14215 for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band*) LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, repair, revision or replacement of (Anaes.) **Fee:** $217.80 **Benefit:** 75% = $163.35 85% = $185.15

31450	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.) **Fee:** $351.95 **Benefit:** 75% = $264.00
31452	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.) **Fee:** $615.75 **Benefit:** 75% = $461.85
31454	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.) **Fee:** $487.50 **Benefit:** 75% = $365.65
31456	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.) **Fee:** $212.55 **Benefit:** 75% = $159.45
31458	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.) **Fee:** $255.05 **Benefit:** 75% = $191.30
31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) **Fee:** $309.00 **Benefit:** 75% = $231.75
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
31464	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Anaes.) (Assist.) *(See para T8.23 of explanatory notes to this Category)* **Fee:** $754.10 **Benefit:** 75% = $565.60
31466	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes.) (Assist.) *(See para T8.23 of explanatory notes to this Category)* **Fee:** $1,131.15 **Benefit:** 75% = $848.40
31468	PARA-OESOPHAGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes.) (Assist.) **Fee:** $1,242.70 **Benefit:** 75% = $932.05
31470	LAPAROSCOPIC SPLENECTOMY (Anaes.) (Assist.) **Fee:** $623.30 **Benefit:** 75% = $467.50
31472	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.) **Fee:** $1,012.45 **Benefit:** 75% = $759.35
31500	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $225.05 **Benefit:** 75% = $168.80 85% = $191.30
31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $300.15 **Benefit:** 75% = $225.15 85% = $255.15
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $337.60 **Benefit:** 75% = $253.20
31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $300.15 **Benefit:** 75% = $225.15 85% = $255.15

31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $562.75 **Benefit:** 75% = $422.10
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $377.45 **Benefit:** 75% = $283.10
31518	BREAST (female), total mastectomy (Anaes.) (Assist.) **Fee:** $637.20 **Benefit:** 75% = $477.90
31521	BREAST (male), total mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.) *(See para T8.28 of explanatory notes to this Category)* **Fee:** $375.15 **Benefit:** 75% = $281.40 85% = $318.90
31524	BREAST (female), subcutaneous mastectomy (Anaes.) (Assist.) *(See para T8.28 of explanatory notes to this Category)* **Fee:** $900.35 **Benefit:** 75% = $675.30
31527	BREAST (male), subcutaneous mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.) *(See para T8.28 of explanatory notes to this Category)* **Fee:** $450.25 **Benefit:** 75% = $337.70 85% = $388.75
31530	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than 1cm in diameter - including pre-operative localisation of lesion where performed, not being a service to which items 31539, 31545 or 31548 apply **Fee:** $515.50 **Benefit:** 75% = $386.65 85% = $454.00
31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) *(See para T8.29 of explanatory notes to this Category)* **Fee:** $119.35 **Benefit:** 75% = $89.55 85% = $101.45
31536	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.) **Fee:** $163.90 **Benefit:** 75% = $122.95 85% = $139.35
31539	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using advanced breast biopsy instrumentation (ABBI), for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.) *(See para T8.30 of explanatory notes to this Category)* **Fee:** $345.15 **Benefit:** 75% = $258.90
31542	BREAST, initial guidewire localisation of lesion, by hookwire or similar device, when conducted by a radiologist as determined by the Royal Australian and New Zealand College of Radiologists, using interventional imaging techniques prior to advanced breast biopsy instrumentation (ABBI), - including imaging not being a service associated with a service to which item 31536 applies (Anaes.) *(See para T8.31 of explanatory notes to this Category)* **Fee:** $170.40 **Benefit:** 75% = $127.80 85% = $144.85
31545	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using advanced breast biopsy instrumentation (ABBI), for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging not being a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.) *(See para T8.30 of explanatory notes to this Category)* **Fee:** $515.50 **Benefit:** 75% = $386.65 85% = $454.00
31548	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using mechanical biopsy device, for histological examination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.) **Fee:** $119.35 **Benefit:** 75% = $89.55 85% = $101.45

31551	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital or day-hospital facility, excluding aftercare (Anaes.) **Fee:** $187.60 **Benefit:** 75% = $140.70 85% = $159.50
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.) **Fee:** $375.15 **Benefit:** 75% = $281.40
31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.) **Fee:** $300.15 **Benefit:** 75% = $225.15 85% = $255.15
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) **Fee:** $300.15 **Benefit:** 75% = $225.15 85% = $255.15
31563	INVERTED NIPPLE, surgical eversion of (Anaes.) **Fee:** $224.85 **Benefit:** 75% = $168.65 85% = $191.15
31566	ACCESSORY NIPPLE, excision of (Anaes.) **Fee:** $112.50 **Benefit:** 75% = $84.40 85% = $95.65
	SUBGROUP 2 - COLORECTAL
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) **Fee:** $892.60 **Benefit:** 75% = $669.45
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) **Fee:** $933.75 **Benefit:** 75% = $700.35
32004	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes.) (Assist.) **Fee:** $995.60 **Benefit:** 75% = $746.70
32005	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes.) (Assist.) **Fee:** $1,124.75 **Benefit:** 75% = $843.60
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.) **Fee:** $995.60 **Benefit:** 75% = $746.70
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) **Fee:** $1,181.00 **Benefit:** 75% = $885.75
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) **Fee:** $1,304.60 **Benefit:** 75% = $978.45
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) **Fee:** $1,603.30 **Benefit:** 75% = $1,202.50
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) **Fee:** $1,359.45 **Benefit:** 75% = $1,019.60
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) **Fee:** $487.50 **Benefit:** 75% = $365.65
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:** $1,181.00 **Benefit:** 75% = $885.75
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:** $1,579.75 **Benefit:** 75% = $1,184.85

32026	RECTUM, ULTRA LOW RESTORATIVE RESECTION, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.) **Fee:** $1,701.20 **Benefit:** 75% = $1,275.90
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.) **Fee:** $1,822.80 **Benefit:** 75% = $1,367.10
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $364.55 **Benefit:** 75% = $273.45
32030	RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes.) (Assist.) **Fee:** $892.60 **Benefit:** 75% = $669.45
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.) **Fee:** $1,304.60 **Benefit:** 75% = $978.45
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) **Fee:** $1,654.65 **Benefit:** 75% = $1,241.00
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) **Fee:** $1,328.55 **Benefit:** 75% = $996.45
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) **Fee:** $1,119.15 **Benefit:** 75% = $839.40
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) **Fee:** $418.85 **Benefit:** 75% = $314.15
32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.) **Fee:** $647.25 **Benefit:** 75% = $485.45
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) **Fee:** $754.10 **Benefit:** 75% = $565.60
32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,004.95 **Benefit:** 75% = $1,503.75
32054	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,840.15 **Benefit:** 75% = $1,380.15
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) **Fee:** $487.50 **Benefit:** 75% = $365.65
32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,004.95 **Benefit:** 75% = $1,503.75
32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,840.15 **Benefit:** 75% = $1,380.15
32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.) **Fee:** $487.50 **Benefit:** 75% = $365.65
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) **Fee:** $1,483.15 **Benefit:** 75% = $1,112.40

32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy **Fee:** $41.45 **Benefit:** 75% = $31.10 85% = $35.25
32075	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $64.95 **Benefit:** 75% = $48.75 85% = $55.25
32078	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is less than or equal to 45 minutes (Anaes.) **Fee:** $145.85 **Benefit:** 75% = $109.40 85% = $124.00
32081	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes.) **Fee:** $200.35 **Benefit:** 75% = $150.30 85% = $170.30
32084	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure, WITH or WITHOUT BIOPSY (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $96.40 **Benefit:** 75% = $72.30 85% = $81.95
32087	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS not being a service to which item 32078 applies (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $177.15 **Benefit:** 75% = $132.90 85% = $150.60
32090	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH or WITHOUT BIOPSY (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $289.30 **Benefit:** 75% = $217.00 85% = $245.95
32093	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $477.55 **Benefit:** 75% = $358.20
32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $110.65 **Benefit:** 75% = $83.00 85% = $94.10
32096	RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day hospital facility (Anaes.) (Assist.) **Fee:** $222.40 **Benefit:** 75% = $166.80 85% = $189.05
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $288.40 **Benefit:** 75% = $216.30
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $549.25 **Benefit:** 75% = $411.95
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 T8.20 and T8.32 of explanatory notes to this Category)* **Fee:** $668.40 **Benefit:** 75% = $501.30
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 T8.20 and T8.32 of explanatory notes to this Category)* **Fee:** $865.15 **Benefit:** 75% = $648.90

32105	ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.) **Fee:** $418.85 **Benefit:** 75% = $314.15 85% = $357.35
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 T8.20 and T8.32 of explanatory notes to this Category)* **Fee:** $1,181.00 **Benefit:** 75% = $885.75 85% = $1,119.50
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) **Fee:** $865.15 **Benefit:** 75% = $648.90
32111	RECTAL PROLAPSE Delorme procedure for (Anaes.) (Assist.) **Fee:** $549.25 **Benefit:** 75% = $411.95
32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.) **Fee:** $668.40 **Benefit:** 75% = $501.30
32114	RECTAL STRICTURE, per anal release of (Anaes.) **Fee:** $151.05 **Benefit:** 75% = $113.30 85% = $128.40
32115	RECTAL STRICTURE, dilatation of (Anaes.) **Fee:** $109.80 **Benefit:** 75% = $82.35
32117	RECTAL PROLAPSE, abdominal rectopexy of (Anaes.) (Assist.) **Fee:** $865.15 **Benefit:** 75% = $648.90
32120	RECTAL PROLAPSE, perineal repair of (Anaes.) (Assist.) **Fee:** $222.40 **Benefit:** 75% = $166.80
32123	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.) **Fee:** $288.40 **Benefit:** 75% = $216.30 85% = $245.15
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.) **Fee:** $418.85 **Benefit:** 75% = $314.15
32129	ANAL SPHINCTER, direct repair of (Anaes.) (Assist.) **Fee:** $549.25 **Benefit:** 75% = $411.95
32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) **Fee:** $461.80 **Benefit:** 75% = $346.35
32132	HAEMORRHOIDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.) **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20
32135	HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.) **Fee:** $58.40 **Benefit:** 75% = $43.80 85% = $49.65
32138	HAEMORRHOIDECTOMY including excision of anal skin tags when performed (Anaes.) **Fee:** $318.25 **Benefit:** 75% = $238.70 85% = $270.55
32139	HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.) (Assist.) **Fee:** $318.25 **Benefit:** 75% = $238.70
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (Anaes.) **Fee:** $58.40 **Benefit:** 75% = $43.80 85% = $49.65
32145	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $116.90 **Benefit:** 75% = $87.70 85% = $99.40
32147	PERIANAL THROMBOSIS, incision of (Anaes.) **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20

32150	OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.) **Fee:** $222.40 **Benefit:** 75% = $166.80 85% = $189.05
32153	ANUS, DILATATION OF, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $60.70 **Benefit:** 75% = $45.55
32156	FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes.) **Fee:** $114.00 **Benefit:** 75% = $85.50 85% = $96.90
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:** $288.40 **Benefit:** 75% = $216.30
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:** $418.85 **Benefit:** 75% = $314.15
32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.) **Fee:** $549.25 **Benefit:** 75% = $411.95 85% = $487.75
32166	ANAL FISTULA - readjustment of Seton (Anaes.) **Fee:** $178.45 **Benefit:** 75% = $133.85 85% = $151.70
32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes.) **Fee:** $114.00 **Benefit:** 75% = $85.50
32171	ANORECTAL EXAMINATION, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $76.85 **Benefit:** 75% = $57.65
32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) **Fee:** $76.85 **Benefit:** 75% = $57.65 85% = $65.35
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital or approved day-hospital facility (excluding aftercare) (Anaes.) **Fee:** $140.75 **Benefit:** 75% = $105.60
32177	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $150.85 **Benefit:** 75% = $113.15
32180	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $222.40 **Benefit:** 75% = $166.80
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) **Fee:** $486.15 **Benefit:** 75% = $364.65
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) **Fee:** $486.15 **Benefit:** 75% = $364.65
32200	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.) **Fee:** $255.90 **Benefit:** 75% = $191.95 85% = $217.55
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.) **Fee:** $549.55 **Benefit:** 75% = $412.20
32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.) **Fee:** $496.50 **Benefit:** 75% = $372.40
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.) **Fee:** $797.90 **Benefit:** 75% = $598.45

32210	GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anaes.) **Fee:** $221.10 **Benefit:** 75% = $165.85 85% = $187.95
32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital or approved day-hospital facility, excluding aftercare (Anaes.) **Fee:** $117.90 **Benefit:** 75% = $88.45 85% = $100.25
H 32213	SACRAL NERVE LEAD(S), placement of, percutaneous using fluoroscopic guidance, or open, and intraoperative test stimulation, for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment (Anaes.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $572.05 **Benefit:** 75% = $429.05
H 32214	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, using fluoroscopic guidance (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $289.00 **Benefit:** 75% = $216.75
H 32215	SACRAL NERVE ELECTRODE(S), management, adjustment, and electronic programming of neurostimulator by a medical practitioner, for the management of faecal incontinence - each day *(See para T8.33 of explanatory notes to this Category)* **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
H 32216	SACRAL NERVE LEAD(S), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, surgical repositioning of, percutaneous using fluoroscopic guidance, or open, to correct displacement or unsatisfactory positioning, and intraoperative test stimulation, not being a service to which item 32213 applies (Anaes.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $513.70 **Benefit:** 75% = $385.30
H 32217	NEUROSTIMULATOR or RECEIVER, inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $135.30 **Benefit:** 75% = $101.50
H 32218	SACRAL NERVE LEAD(S), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $135.30 **Benefit:** 75% = $101.50
	SUBGROUP 3 - VASCULAR
	VARICOSE VEINS
32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding after-care) - to a maximum of 6 treatments in a 12 month period (Anaes.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
32501	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg, (excluding after-care) where it can be demonstrated that truncal reflux in the long or short saphenous veins has been excluded by duplex examination ***- and that a 7th or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12 month period*** *(See para T8.34 of explanatory notes to this Category)* **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
32504	VARICOSE VEINS, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) **Fee:** $231.65 **Benefit:** 75% = $173.75 85% = $196.95

32507	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (Assist.) **Fee:** $461.80 **Benefit:** 75% = $346.35 85% = $400.30
32508	VARICOSE VEINS, complete dissection at the sapheno-femoral **OR** sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) **Fee:** $461.80 **Benefit:** 75% = $346.35
32511	VARICOSE VEINS, complete dissection at the sapheno-femoral **AND** sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) **Fee:** $686.60 **Benefit:** 75% = $514.95
32514	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) **Fee:** $802.10 **Benefit:** 75% = $601.60
32517	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) **Fee:** $1,032.85 **Benefit:** 75% = $774.65
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,243.05 **Benefit:** 75% = $932.30
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.) **Fee:** $1,028.35 **Benefit:** 75% = $771.30
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) **Fee:** $1,230.10 **Benefit:** 75% = $922.60
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) **Fee:** $1,366.85 **Benefit:** 75% = $1,025.15
32711	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.) (Assist.) **Fee:** $1,503.55 **Benefit:** 75% = $1,127.70
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,086.90 **Benefit:** 75% = $815.20
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) **Fee:** $1,086.90 **Benefit:** 75% = $815.20
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,028.35 **Benefit:** 75% = $771.30
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) **Fee:** $1,633.45 **Benefit:** 75% = $1,225.10
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,854.80 **Benefit:** 75% = $1,391.10
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,405.75 **Benefit:** 75% = $1,054.35
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,633.45 **Benefit:** 75% = $1,225.10
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) **Fee:** $357.90 **Benefit:** 75% = $268.45

32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.) **Fee:** $1,119.40 **Benefit:** 75% = $839.55
32742	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.) **Fee:** $1,282.20 **Benefit:** 75% = $961.65
32745	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes.) (Assist.) **Fee:** $1,464.30 **Benefit:** 75% = $1,098.25
32748	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.) **Fee:** $1,588.00 **Benefit:** 75% = $1,191.00
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) **Fee:** $1,028.35 **Benefit:** 75% = $771.30
32754	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.) (Assist.) **Fee:** $1,282.20 **Benefit:** 75% = $961.65
32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes.) (Assist.) **Fee:** $357.90 **Benefit:** 75% = $268.45
32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,028.35 **Benefit:** 75% = $771.30
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.) **Fee:** $683.40 **Benefit:** 75% = $512.55
32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.) **Fee:** $236.90 **Benefit:** 75% = $177.70
	BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS
33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.) **Fee:** $1,259.50 **Benefit:** 75% = $944.65
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) **Fee:** $1,010.05 **Benefit:** 75% = $757.55
33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $728.75 **Benefit:** 75% = $546.60 85% = $667.25
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $927.05 **Benefit:** 75% = $695.30
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,131.55 **Benefit:** 75% = $848.70
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,243.05 **Benefit:** 75% = $932.30 85% = $1,181.55

33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $1,744.10 **Benefit:** 75% = $1,308.10
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,108.70 **Benefit:** 75% = $1,581.55 85% = $2,047.20
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $1,828.80 **Benefit:** 75% = $1,371.60
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) **Fee:** $1,230.10 **Benefit:** 75% = $922.60
+ 33116	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Ministerial Determination) (Anaes.) (Assist.) *(See para T8.35 of explanatory notes to this Category)* **Fee:** $1,210.75 **Benefit:** 75% = $908.10 85% = $1,149.25
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.) **Fee:** $1,366.85 **Benefit:** 75% = $1,025.15
+ 33119	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Ministerial Determination) (Anaes.) (Assist.) *(See para T8.35 of explanatory notes to this Category)* **Fee:** $1,345.40 **Benefit:** 75% = $1,009.05 85% = $1,283.90
33121	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $1,503.55 **Benefit:** 75% = $1,127.70
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.) **Fee:** $1,047.85 **Benefit:** 75% = $785.90
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.) **Fee:** $1,373.25 **Benefit:** 75% = $1,029.95 85% = $1,311.75
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) **Fee:** $1,197.50 **Benefit:** 75% = $898.15
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) **Fee:** $898.10 **Benefit:** 75% = $673.60
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) **Fee:** $2,264.75 **Benefit:** 75% = $1,698.60
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,373.25 **Benefit:** 75% = $1,029.95
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,282.20 **Benefit:** 75% = $961.65 85% = $1,220.70
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,206.25 **Benefit:** 75% = $1,654.70
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,739.90 **Benefit:** 75% = $2,054.95
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,603.25 **Benefit:** 75% = $1,952.45
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) **Fee:** $1,926.45 **Benefit:** 75% = $1,444.85

33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $2,147.65 **Benefit:** 75% = $1,610.75
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) **Fee:** $2,147.65 **Benefit:** 75% = $1,610.75
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $1,822.45 **Benefit:** 75% = $1,366.85
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) **Fee:** $1,822.45 **Benefit:** 75% = $1,366.85 85% = $1,760.95
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) **Fee:** $1,418.80 **Benefit:** 75% = $1,064.10
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,106.35 **Benefit:** 75% = $829.80
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,019.65 **Benefit:** 75% = $764.75
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,296.60 **Benefit:** 75% = $972.45
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,585.30 **Benefit:** 75% = $1,189.00
	ENDARTERECTOMY AND ARTERIAL PATCH
33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.) **Fee:** $982.65 **Benefit:** 75% = $737.00
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $1,099.95 **Benefit:** 75% = $825.00
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) **Fee:** $1,230.10 **Benefit:** 75% = $922.60
33512	AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes.) (Assist.) **Fee:** $1,366.85 **Benefit:** 75% = $1,025.15
33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.) (Assist.) **Fee:** $1,503.55 **Benefit:** 75% = $1,127.70
33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.) **Fee:** $1,099.95 **Benefit:** 75% = $825.00 85% = $1,038.45
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) **Fee:** $1,190.95 **Benefit:** 75% = $893.25
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,405.75 **Benefit:** 75% = $1,054.35
33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) **Fee:** $1,633.45 **Benefit:** 75% = $1,225.10

33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,405.75 **Benefit:** 75% = $1,054.35
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,633.45 **Benefit:** 75% = $1,225.10
33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,165.05 **Benefit:** 75% = $873.80
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $839.55 **Benefit:** 75% = $629.70
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.) **Fee:** $1,197.50 **Benefit:** 75% = $898.15
33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $236.90 **Benefit:** 75% = $177.70
33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $481.75 **Benefit:** 75% = $361.35
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $236.90 **Benefit:** 75% = $177.70
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.) **Fee:** $235.70 **Benefit:** 75% = $176.80
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
33800	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.) **Fee:** $1,021.80 **Benefit:** 75% = $766.35 85% = $960.30
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) **Fee:** $976.25 **Benefit:** 75% = $732.20
33806	EMBOLECTOMY OR THROMBECTOMY, including the infusion of thrombolytic or other agents, from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery (Anaes.) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $702.90 **Benefit:** 75% = $527.20 85% = $641.40
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.) **Fee:** $512.75 **Benefit:** 75% = $384.60 85% = $451.25
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) **Fee:** $1,526.45 **Benefit:** 75% = $1,144.85
33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.) **Fee:** $807.00 **Benefit:** 75% = $605.25 85% = $745.50
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $741.95 **Benefit:** 75% = $556.50
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $865.60 **Benefit:** 75% = $649.20
33821	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $989.25 **Benefit:** 75% = $741.95

33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $943.65 **Benefit:** 75% = $707.75
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,106.35 **Benefit:** 75% = $829.80
33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $1,269.05 **Benefit:** 75% = $951.80
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) **Fee:** $1,152.05 **Benefit:** 75% = $864.05
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,373.25 **Benefit:** 75% = $1,029.95
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) **Fee:** $1,607.50 **Benefit:** 75% = $1,205.65
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) **Fee:** $794.00 **Benefit:** 75% = $595.50
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $553.20 **Benefit:** 75% = $414.90
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $553.20 **Benefit:** 75% = $414.90
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.) **Fee:** $611.85 **Benefit:** 75% = $458.90
34103	GREAT ARTERY OR GREAT VEIN (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.) **Fee:** $357.90 **Benefit:** 75% = $268.45
34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.) **Fee:** $252.50 **Benefit:** 75% = $189.40 85% = $214.65
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) **Fee:** $292.80 **Benefit:** 75% = $219.60 85% = $248.90
34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) **Fee:** $741.95 **Benefit:** 75% = $556.50
34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) **Fee:** $839.55 **Benefit:** 75% = $629.70
34118	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,197.50 **Benefit:** 75% = $898.15 85% = $1,136.00
34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $956.65 **Benefit:** 75% = $717.50

34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,047.85 **Benefit:** 75% = $785.90
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,373.25 **Benefit:** 75% = $1,029.95
34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) **Fee:** $429.55 **Benefit:** 75% = $322.20 85% = $368.05
34133	SCALENOTOMY (Anaes.) (Assist.) **Fee:** $481.75 **Benefit:** 75% = $361.35
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) **Fee:** $774.40 **Benefit:** 75% = $580.80
34139	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $774.40 **Benefit:** 75% = $580.80
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) **Fee:** $956.65 **Benefit:** 75% = $717.50
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) **Fee:** $696.40 **Benefit:** 75% = $522.30
34148	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.) **Fee:** $1,243.05 **Benefit:** 75% = $932.30
34151	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.) **Fee:** $1,698.65 **Benefit:** 75% = $1,274.00
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) **Fee:** $2,024.10 **Benefit:** 75% = $1,518.10 85% = $1,962.60
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) **Fee:** $1,028.35 **Benefit:** 75% = $771.30
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) **Fee:** $1,926.45 **Benefit:** 75% = $1,444.85
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,473.10 **Benefit:** 75% = $1,854.85
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) **Fee:** $2,473.10 **Benefit:** 75% = $1,854.85
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,373.25 **Benefit:** 75% = $1,029.95
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,119.40 **Benefit:** 75% = $839.55
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) **Fee:** $1,028.35 **Benefit:** 75% = $771.30
	OPERATIONS FOR VASCULAR ACCESS
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.) **Fee:** $266.90 **Benefit:** 75% = $200.20 85% = $226.90

34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $357.90 **Benefit:** 75% = $268.45
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) **Fee:** $182.15 **Benefit:** 75% = $136.65
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $846.05 **Benefit:** 75% = $634.55
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) **Fee:** $930.70 **Benefit:** 75% = $698.05
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) **Fee:** $663.80 **Benefit:** 75% = $497.85
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) **Fee:** $1,112.85 **Benefit:** 75% = $834.65
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) **Fee:** $683.65 **Benefit:** 75% = $512.75
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) **Fee:** $357.90 **Benefit:** 75% = $268.45
34527	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation (Anaes.) **Fee:** $477.40 **Benefit:** 75% = $358.05 85% = $415.90
34528	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device (Anaes.) **Fee:** $235.70 **Benefit:** 75% = $176.80 85% = $200.35
34530	HICKMAN OR BROVIAC CATHETER, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital or approved day-hospital (Anaes.) **Fee:** $176.80 **Benefit:** 75% = $132.60 85% = $150.30
34533	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes.) (Assist.) **Fee:** $1,073.80 **Benefit:** 75% = $805.35 85% = $1,012.30
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:** $235.70 **Benefit:** 75% = $176.80 85% = $200.35
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:** $176.80 **Benefit:** 75% = $132.60 85% = $150.30
	COMPLEX VENOUS OPERATIONS
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) **Fee:** $702.90 **Benefit:** 75% = $527.20 85% = $641.40
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,549.00 **Benefit:** 75% = $1,161.75
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) **Fee:** $839.55 **Benefit:** 75% = $629.70

34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) **Fee:** $839.55 **Benefit:** 75% = $629.70
34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.) **Fee:** $1,015.30 **Benefit:** 75% = $761.50
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $839.55 **Benefit:** 75% = $629.70
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) **Fee:** $924.15 **Benefit:** 75% = $693.15
34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) **Fee:** $1,256.15 **Benefit:** 75% = $942.15 85% = $1,194.65
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) **Fee:** $429.55 **Benefit:** 75% = $322.20
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) **Fee:** $520.65 **Benefit:** 75% = $390.50
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) **Fee:** $611.85 **Benefit:** 75% = $458.90 85% = $550.35
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) **Fee:** $794.00 **Benefit:** 75% = $595.50
	SYMPATHECTOMY
35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $611.85 **Benefit:** 75% = $458.90 85% = $550.35
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) **Fee:** $794.00 **Benefit:** 75% = $595.50
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) **Fee:** $995.80 **Benefit:** 75% = $746.85
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) **Fee:** $774.40 **Benefit:** 75% = $580.80
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $611.85 **Benefit:** 75% = $458.90
	DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
35100	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.) **Fee:** $319.00 **Benefit:** 75% = $239.25
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) **Fee:** $203.05 **Benefit:** 75% = $152.30 85% = $172.60
	MISCELLANEOUS VASCULAR PROCEDURES
35200	OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of an operative procedure on an artery or vein, 1 site (Anaes.) **Fee:** $148.45 **Benefit:** 75% = $111.35

35202	MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.) **Fee:** $707.20 **Benefit:** 75% = $530.40
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
35300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $446.10 **Benefit:** 75% = $334.60 85% = $384.60
35303	TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $571.90 **Benefit:** 75% = $428.95 85% = $510.40
35306	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $527.85 **Benefit:** 75% = $395.90 85% = $466.35
H 35307	TRANSLUMINAL STENT INSERTION, 1 or more stents (not drug-eluting), with or without associated balloon dilatation, for 1 carotid artery, percutaneous (not direct), with or without the use of an embolic protection device, in patients who: - meet the indications for carotid endarterectomy; and - have medical or surgical comorbidities that would make them at high risk of perioperative complications from carotid endarterectomy, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.38 of explanatory notes to this Category)* **Fee:** $970.35 **Benefit:** 75% = $727.80
35309	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $659.85 **Benefit:** 75% = $494.90 85% = $598.35
35312	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $747.80 **Benefit:** 75% = $560.85
35315	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $747.80 **Benefit:** 75% = $560.85
35317	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $307.95 **Benefit:** 75% = $231.00 85% = $261.80
35319	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $552.00 **Benefit:** 75% = $414.00 85% = $490.50
35320	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15 85% = $680.00

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 T8.40 of explanatory notes to this Category)* **Fee:** $703.85 **Benefit:** 75% = $527.90 85% = $642.35
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $263.85 **Benefit:** 75% = $197.90
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $353.70 **Benefit:** 75% = $265.30
35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $446.10 **Benefit:** 75% = $334.60 85% = $384.60
35331	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.) **Fee:** $512.75 **Benefit:** 75% = $384.60
35360	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare ***(foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $716.75 **Benefit:** 75% = $537.60
35361	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare ***(foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $614.75 **Benefit:** 75% = $461.10
35362	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare ***(foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $512.75 **Benefit:** 75% = $384.60
35363	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare ***(foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $410.75 **Benefit:** 75% = $308.10
	SUBGROUP 4 - GYNAECOLOGICAL
35500	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $70.30 **Benefit:** 75% = $52.75 85% = $59.80
35502	INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopathic menorrhagia, AND ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $69.40 **Benefit:** 75% = $52.05 85% = $59.00
35503	INTRAUTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $46.35 **Benefit:** 75% = $34.80 85% = $39.40
35506	INTRAUTERINE CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $46.45 **Benefit:** 75% = $34.85 85% = $39.50

35507	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) **Fee:** $151.05	**Benefit:** 75% = $113.30	85% = $128.40
35508	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) (Assist.) **Fee:** $222.40	**Benefit:** 75% = $166.80	85% = $189.05
35509	HYMENECTOMY (Anaes.) **Fee:** $77.45	**Benefit:** 75% = $58.10	85% = $65.85
35512 G 35513 S	BARTHOLIN'S CYST, excision of (Anaes.) **Fee:** $155.25 **Fee:** $191.90	**Benefit:** 75% = $116.45 **Benefit:** 75% = $143.95	85% = $132.00 85% = $163.15
35516 G 35517 S	BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes.) **Fee:** $100.75 **Fee:** $126.35	**Benefit:** 75% = $75.60 **Benefit:** 75% = $94.80	85% = $85.65 85% = $107.40
35518	OVARIAN CYST ASPIRATION, for cysts of at least 4cm in diameter in premenopausal women and at least 2cm in diameter in postmenopausal women, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.) **Fee:** $179.85	**Benefit:** 75% = $134.90	85% = $152.90
35520	BARTHOLIN'S ABSCESS, incision of (Anaes.) **Fee:** $50.45	**Benefit:** 75% = $37.85	85% = $42.90
35523	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.) **Fee:** $50.45	**Benefit:** 75% = $37.85	85% = $42.90
35526 G 35527 S	URETHRAL CARUNCLE, excision of (Anaes.) **Fee:** $100.75 **Fee:** $126.35	**Benefit:** 75% = $75.60 **Benefit:** 75% = $94.80	85% = $85.65 85% = $107.40
35530	CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.) **Fee:** $233.50	**Benefit:** 75% = $175.15	
35533	VULVOPLASTY or LABIOPLASTY, where medically indicated, not being a service associated with a service to which item 35536 applies (Anaes.) **Fee:** $302.80	**Benefit:** 75% = $227.10	85% = $257.40
35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.) (Assist.) **Fee:** $301.55	**Benefit:** 75% = $226.20	85% = $256.35
35539	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes.) **Fee:** $236.25	**Benefit:** 75% = $177.20	85% = $200.85
35542	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Anaes.) (Assist.) **Fee:** $276.60	**Benefit:** 75% = $207.45	85% = $235.15
35545	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes.) **Fee:** $158.95	**Benefit:** 75% = $119.25	85% = $135.15
35548	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.) **Fee:** $721.90	**Benefit:** 75% = $541.45	
35551	PELVIC LYMPH GLANDS, excision of (radical) (Anaes.) (Assist.) **Fee:** $591.85	**Benefit:** 75% = $443.90	
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.) **Fee:** $37.65	**Benefit:** 75% = $28.25	85% = $32.05

35557	VAGINA, removal of simple tumour (including Gartner duct cyst) (Anaes.) **Fee:** $185.65 **Benefit:** 75% = $139.25 85% = $157.85
35560	VAGINA, partial or complete removal of (Anaes.) (Assist.) **Fee:** $591.85 **Benefit:** 75% = $443.90
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,194.00 **Benefit:** 75% = $895.50
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $980.25 **Benefit:** 75% = $735.20
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) **Fee:** $591.85 **Benefit:** 75% = $443.90
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.) **Fee:** $343.85 **Benefit:** 75% = $257.90
35568	SACROSPINOUS COLPOPEXY FOR MANAGEMENT OF UPPER VAGINAL PROLAPSE (Anaes.) (Assist.) **Fee:** $540.60 **Benefit:** 75% = $405.45
35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.) **Fee:** $139.20 **Benefit:** 75% = $104.40 85% = $118.35
35570	ANTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving repair of urethrocoele and cystocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $479.40 **Benefit:** 75% = $359.55
35571	POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving one or more of the following; repair of perineum, rectocoele or enterocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $479.40 **Benefit:** 75% = $359.55
35572	COLPOTOMY not being a service to which another item in this Group applies (Anaes.) **Fee:** $107.15 **Benefit:** 75% = $80.40
35573	ANTERIOR AND POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving both anterior and posterior compartment defects) with or without mesh, not being a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $719.10 **Benefit:** 75% = $539.35
35577	MANCHESTER (DONALD FOTHERGILL) OPERATION for genital prolapse, with or without mesh (Anaes.) (Assist.) **Fee:** $583.75 **Benefit:** 75% = $437.85
35578	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $583.75 **Benefit:** 75% = $437.85
35595	LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCORPORATING THE FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENTS TO RECTOVAGINAL AND PUBOCERVICAL FASCIA for symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $999.60 **Benefit:** 75% = $749.70
35596	FISTULA BETWEEN GENITAL AND URINARY OR ALIMENTARY TRACTS, repair of, not being a service to which item 37029, 37333 or 37336 applies (Anaes.) (Assist.) **Fee:** $591.85 **Benefit:** 75% = $443.90
35597	SACRAL COLPOPEXY, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,275.00 **Benefit:** 75% = $956.25

35599	STRESS INCONTINENCE, sling operation for, with or without mesh or tape, not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $583.75 **Benefit:** 75% = $437.85
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:** $583.75 **Benefit:** 75% = $437.85
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:** $316.70 **Benefit:** 75% = $237.55 85% = $269.20
35608	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.) **Fee:** $55.35 **Benefit:** 75% = $41.55 85% = $47.05
35611	CERVIX, removal of polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.) **Fee:** $55.35 **Benefit:** 75% = $41.55 85% = $47.05
35612	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.) **Fee:** $437.90 **Benefit:** 75% = $328.45 85% = $376.40
35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.) **Fee:** $350.35 **Benefit:** 75% = $262.80
35614	EXAMINATION OF LOWER FEMALE GENITAL TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $55.25 **Benefit:** 75% = $41.45 85% = $47.00
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies **Fee:** $46.45 **Benefit:** 75% = $34.85 85% = $39.50
35616	ENDOMETRIUM, endoscopic examination of and ablation of, by microwave or thermal balloon, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.) **Fee:** $389.10 **Benefit:** 75% = $291.85
35617 G 35618 S	CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35577 or 35578 applies (Anaes.) **Fee:** $150.30 **Benefit:** 75% = $112.75 85% = $127.80 **Fee:** $188.65 **Benefit:** 75% = $141.50 85% = $160.40
35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.) **Fee:** $46.15 **Benefit:** 75% = $34.65 85% = $39.25
35622	ENDOMETRIUM, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (Anaes.) **Fee:** $521.40 **Benefit:** 75% = $391.05
35623	HYSTEROSCOPIC RESECTION of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $709.00 **Benefit:** 75% = $531.75
35626	HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies *(See para T8.44 of explanatory notes to this Category)* **Fee:** $71.70 **Benefit:** 75% = $53.80 85% = $60.95
35627	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital or approved day-hospital facility - not being a service associated with a service to which item 35626 or 35630 applies (Anaes.) **Fee:** $92.70 **Benefit:** 75% = $69.55

35630	HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital or approved day-hospital facility - not being a service associated with a service to which item 35626 or 35627 applies (Anaes.) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
35633	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of IUD which cannot be removed by other means, 1 or more of (Anaes.) **Fee:** $188.65 **Benefit:** 75% = $141.50 85% = $160.40
35634	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $593.45 **Benefit:** 75% = $445.10 85% = $531.95
35635	HYSTEROSCOPY involving resection of the uterine septum (Anaes.) **Fee:** $259.20 **Benefit:** 75% = $194.40
35636	HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.) **Fee:** $374.80 **Benefit:** 75% = $281.10
35637	LAPAROSCOPY, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes.) (Assist.) **Fee:** $351.95 **Benefit:** 75% = $264.00
35638	COMPLICATED OPERATIVE LAPAROSCOPY, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal or retroperitoneal procedure except item 30393 (Anaes.) (Assist.) **Fee:** $615.75 **Benefit:** 75% = $461.85
35639 G 35640 S	UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day hospital facility, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.) *(See para T8.45 of explanatory notes to this Category)* **Fee:** $116.80 **Benefit:** 75% = $87.60 **Fee:** $158.40 **Benefit:** 75% = $118.80
35641	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RESECTION OF, involving any two of the following procedures, resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes.) (Assist.) **Fee:** $1,075.50 **Benefit:** 75% = $806.65
35643	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.) **Fee:** $188.65 **Benefit:** 75% = $141.50 85% = $160.40
35644	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35639, 35640 or 35647 applies (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $176.25 **Benefit:** 75% = $132.20 85% = $149.85
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $275.85 **Benefit:** 75% = $206.90 85% = $234.50
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $176.25 **Benefit:** 75% = $132.20 85% = $149.85

35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $176.25 **Benefit:** 75% = $132.20 85% = $149.85
35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $275.85 **Benefit:** 75% = $206.90 85% = $234.50
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.) **Fee:** $463.90 **Benefit:** 75% = $347.95
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $583.90 **Benefit:** 75% = $437.95
35657	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) (Assist.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $583.90 **Benefit:** 75% = $437.95
35658	UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.) (Assist.) *(See para T8.48 of explanatory notes to this Category)* **Fee:** $360.05 **Benefit:** 75% = $270.05
35661	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (Anaes.) (Assist.) **Fee:** $754.10 **Benefit:** 75% = $565.60
35664	RADICAL HYSTERECTOMY with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,256.80 **Benefit:** 75% = $942.60
35667	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,068.15 **Benefit:** 75% = $801.15
35670	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $879.60 **Benefit:** 75% = $659.70
35673	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.) **Fee:** $655.80 **Benefit:** 75% = $491.85
35674	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy **Fee:** $179.85 **Benefit:** 75% = $134.90 85% = $152.90
35676 G 35677 S	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.) **Fee:** $367.80 **Benefit:** 75% = $275.85 **Fee:** $463.90 **Benefit:** 75% = $347.95
35678	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.) **Fee:** $559.30 **Benefit:** 75% = $419.50
35680	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.) **Fee:** $503.75 **Benefit:** 75% = $377.85 85% = $442.25

	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.)
35683 G	**Fee:** $304.00 **Benefit:** 75% = $228.00
35684 S	**Fee:** $407.80 **Benefit:** 75% = $305.85
	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method. **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) (Assist.) *(See para T8.47 of explanatory notes to this Category)*
35687 G	**Fee:** $281.50 **Benefit:** 75% = $211.15
35688 S	**Fee:** $343.85 **Benefit:** 75% = $257.90
	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explantory note before submitting a claim***. (Anaes.) (Assist.) *(See para T8.47 of explanatory notes to this Category)*
35691	**Fee:** $137.35 **Benefit:** 75% = $103.05
	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)
35694	**Fee:** $551.90 **Benefit:** 75% = $413.95
	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)
35697	**Fee:** $818.90 **Benefit:** 75% = $614.20
	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope, for other than reversal of previous sterilisation (Anaes.) (Assist.) *(See para T8.49 of explanatory notes to this Category)*
35700	**Fee:** $631.90 **Benefit:** 75% = $473.95
	HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure not being a service associated with a service to which another item in this Sub-group applies (Anaes.)
35703	**Fee:** $58.40 **Benefit:** 75% = $43.80 85% = $49.65
	RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes.)
35706	**Fee:** $58.40 **Benefit:** 75% = $43.80 85% = $49.65
	FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes.)
35709	**Fee:** $37.65 **Benefit:** 75% = $28.25 85% = $32.05
	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.)
35710	**Fee:** $401.00 **Benefit:** 75% = $300.75
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 1 such procedure, not being a service associated with hysterectomy (Anaes.) (Assist.)
35712 G	**Fee:** $313.45 **Benefit:** 75% = $235.10
35713 S	**Fee:** $391.95 **Benefit:** 75% = $294.00
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Anaes.) (Assist.)
35716 G	**Fee:** $375.90 **Benefit:** 75% = $281.95
35717 S	**Fee:** $471.90 **Benefit:** 75% = $353.95
	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.) *(See para T8.55 of explanatory notes to this Category)*
35720	**Fee:** $583.75 **Benefit:** 75% = $437.85

35723	RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) **Fee:** $418.10 **Benefit:** 75% = $313.60
35726	INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) **Fee:** $418.10 **Benefit:** 75% = $313.60
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.) **Fee:** $188.50 **Benefit:** 75% = $141.40
35750	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $679.05 **Benefit:** 75% = $509.30
35753	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $750.90 **Benefit:** 75% = $563.20
35754	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Anaes.) (Assist.) **Fee:** $944.95 **Benefit:** 75% = $708.75
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $679.05 **Benefit:** 75% = $509.30
35759	Procedure for the control of POST OPERATIVE HAEMORRHAGE following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Anaes.) (Assist.) **Fee:** $487.50 **Benefit:** 75% = $365.65
	SUBGROUP 5 - UROLOGICAL
	GENERAL
36500	ADRENAL GLAND, excision of partial or total (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $591.85 **Benefit:** 75% = $443.90
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) **Fee:** $1,204.00 **Benefit:** 75% = $903.00
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) **Fee:** $677.65 **Benefit:** 75% = $508.25
36516	NEPHRECTOMY, complete (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
36519	NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,117.45 **Benefit:** 75% = $838.10
36522	NEPHRECTOMY, partial (Anaes.) (Assist.) **Fee:** $958.90 **Benefit:** 75% = $719.20
36525	NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,362.65 **Benefit:** 75% = $1,022.00

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 T8.50 of explanatory notes to this Category)* **Fee:** $1,117.45 **Benefit:** 75% = $838.10 85% = $1,055.95
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 T8.50 of explanatory notes to this Category)* **Fee:** $1,379.05 **Benefit:** 75% = $1,034.30 85% = $1,317.55
36528	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cms in diameter (Anaes.) (Assist.) **Fee:** $1,117.45 **Benefit:** 75% = $838.10
36529	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,379.05 **Benefit:** 75% = $1,034.30
36531	NEPHROURETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $1,002.05 **Benefit:** 75% = $751.55
36532	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $1,438.30 **Benefit:** 75% = $1,078.75
36533	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (Anaes.) (Assist.) **Fee:** $1,699.90 **Benefit:** 75% = $1,274.95
36537	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $598.40 **Benefit:** 75% = $448.80
36540	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (Anaes.) (Assist.) **Fee:** $958.90 **Benefit:** 75% = $719.20 85% = $897.40
36543	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.) **Fee:** $1,117.45 **Benefit:** 75% = $838.10 85% = $1,055.95
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) **Fee:** $598.40 **Benefit:** 75% = $448.80 85% = $536.90
36549	URETEROLITHOTOMY (Anaes.) (Assist.) **Fee:** $721.00 **Benefit:** 75% = $540.75
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) **Fee:** $562.40 **Benefit:** 75% = $421.80 85% = $500.90
36561	RENAL BIOPSY (closed) (Anaes.) **Fee:** $149.30 **Benefit:** 75% = $112.00 85% = $126.95
36564	PYELOPLASTY, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20

36567	PYELOPLASTY in a kidney that is congenitally abnormal in addition to the presence of PUJ obstruction, or in a solitary kidney, by open exposure (Anaes.) (Assist.) **Fee:** $879.60 **Benefit:** 75% = $659.70
36570	PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (Anaes.) (Assist.) **Fee:** $1,117.45 **Benefit:** 75% = $838.10
36573	DIVIDED URETER, repair of (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
36576	KIDNEY, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.) (Assist.) **Fee:** $1,002.05 **Benefit:** 75% = $751.55
36579	URETERECTOMY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
36585	URETER, transplantation of, into skin (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
36588	URETER, reimplantation into bladder (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) **Fee:** $958.90 **Benefit:** 75% = $719.20
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) **Fee:** $958.90 **Benefit:** 75% = $719.20 85% = $897.40
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) **Fee:** $1,117.45 **Benefit:** 75% = $838.10
36604	URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.) **Fee:** $231.65 **Benefit:** 75% = $173.75 85% = $196.95
36605	URETERIC STENT, insertion of, with removal of calculus from: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.) **Fee:** $597.70 **Benefit:** 75% = $448.30
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) **Fee:** $2,004.25 **Benefit:** 75% = $1,503.20
36607	URETERIC STENT insertion of, with baloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.) **Fee:** $597.70 **Benefit:** 75% = $448.30
36608	URETERIC STENT, exchange of, percutaneously through either the ileal conduit or bladder, using interventional imaging techniques, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.) **Fee:** $231.65 **Benefit:** 75% = $173.75
36609	INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35

36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) **Fee:** $562.40 **Benefit:** 75% = $421.80
36615	URETEROLYSIS, with or without repositioning of the ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) **Fee:** $562.40 **Benefit:** 75% = $421.80
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) **Fee:** $402.00 **Benefit:** 75% = $301.50
36624	NEPHROSTOMY, percutaneous, using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $483.00 **Benefit:** 75% = $362.25 85% = $421.50
36627	NEPHROSCOPY, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.) **Fee:** $598.40 **Benefit:** 75% = $448.80
36630	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) **Fee:** $295.60 **Benefit:** 75% = $221.70
36633	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35 85% = $580.25
36636	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $346.15 **Benefit:** 75% = $259.65
36639	NEPHROSCOPY, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes.) **Fee:** $721.00 **Benefit:** 75% = $540.75
36642	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) **Fee:** $360.45 **Benefit:** 75% = $270.35
36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes.) (Assist.) **Fee:** $922.80 **Benefit:** 75% = $692.10
36648	NEPHROSCOPY, being a service to which item 36645 applies, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION (Anaes.) (Assist.) **Fee:** $821.90 **Benefit:** 75% = $616.45
36649	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (Anaes.) (Assist.) **Fee:** $231.65 **Benefit:** 75% = $173.75 85% = $196.95
36650	NEPHROSTOMY TUBE, removal of, if the ureter has been stented with a double J ureteric stent and that stent is left in place, using interventional imaging techniques (Anaes.) **Fee:** $129.55 **Benefit:** 75% = $97.20
36652	PYELOSCOPY, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Anaes.) (Assist.) **Fee:** $562.40 **Benefit:** 75% = $421.80
36654	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system (Assist.) **Fee:** $721.00 **Benefit:** 75% = $540.75

36656	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.) (Assist.) **Fee:** $922.80 **Benefit:** 75% = $692.10
	OPERATIONS ON THE BLADDER (CLOSED)
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) **Fee:** $23.90 **Benefit:** 75% = $17.95 85% = $20.35
36803	URETEROSCOPY, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Anaes.) (Assist.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $403.60 **Benefit:** 75% = $302.70 85% = $343.10
36806	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) **Fee:** $562.40 **Benefit:** 75% = $421.80
36809	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, PLUS destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) **Fee:** $721.00 **Benefit:** 75% = $540.75
36811	CYSTOSCOPY with insertion of urethral prosthesis (Anaes.) **Fee:** $279.90 **Benefit:** 75% = $209.95 85% = $237.95
36812	CYSTOSCOPY with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.) **Fee:** $144.25 **Benefit:** 75% = $108.20 85% = $122.65
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $205.90 **Benefit:** 75% = $154.45 85% = $175.05
36818	CYSTOSCOPY with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45
36821	CYSTOSCOPY with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) **Fee:** $279.75 **Benefit:** 75% = $209.85 85% = $237.80
36824	CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.) **Fee:** $184.45 **Benefit:** 75% = $138.35 85% = $156.80
36825	CYSTOSCOPY, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818, 36821, 36824, 36830 or 36833 applies (Anaes.) (Assist.) **Fee:** $503.10 **Benefit:** 75% = $377.35
36827	CYSTOSCOPY, with controlled hydrodilatation of the bladder (Anaes.) **Fee:** $198.95 **Benefit:** 75% = $149.25 85% = $169.15
36830	CYSTOSCOPY, with ureteric meatotomy (Anaes.) **Fee:** $175.95 **Benefit:** 75% = $132.00
36833	CYSTOSCOPY, with removal of ureteric stent or other foreign body (Anaes.) (Assist.) **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45

36836	CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206 or 37215 applies (Anaes.) **Fee:** $198.95 **Benefit:** 75% = $149.25 85% = $169.15
36840	CYSTOSCOPY, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36845 applies (Anaes.) **Fee:** $279.75 **Benefit:** 75% = $209.85 85% = $237.80
36842	CYSTOSCOPY, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812, 36827 to 36863, 37203 or 37206 apply (Anaes.) (Assist.) **Fee:** $281.50 **Benefit:** 75% = $211.15
36845	CYSTOSCOPY, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter (Anaes.) **Fee:** $598.40 **Benefit:** 75% = $448.80
36848	CYSTOSCOPY, with resection of ureterocele (Anaes.) **Fee:** $198.95 **Benefit:** 75% = $149.25
36851	CYSTOSCOPY, with injection into bladder wall (Anaes.) **Fee:** $198.95 **Benefit:** 75% = $149.25
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) **Fee:** $403.60 **Benefit:** 75% = $302.70
36857	ENDOSCOPIC MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.) **Fee:** $317.15 **Benefit:** 75% = $237.90
36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes.) **Fee:** $144.25 **Benefit:** 75% = $108.20 85% = $122.65
36863	LITHOLAPAXY, with or without cystoscopy (Anaes.) (Assist.) **Fee:** $403.60 **Benefit:** 75% = $302.70
	OPERATIONS ON THE BLADDER (OPEN)
37000	BLADDER, partial excision of (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
37004	BLADDER, repair of rupture (Anaes.) (Assist.) **Fee:** $562.40 **Benefit:** 75% = $421.80
37008	CYSTOSTOMY OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies and not being a service associated with other open bladder procedure (Anaes.) **Fee:** $360.45 **Benefit:** 75% = $270.35 85% = $306.40
37011	SUPRAPUBIC STAB CYSTOTOMY, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.) **Fee:** $80.75 **Benefit:** 75% = $60.60 85% = $68.65
37014	BLADDER, total excision of (Anaes.) (Assist.) **Fee:** $922.80 **Benefit:** 75% = $692.10
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) **Fee:** $360.45 **Benefit:** 75% = $270.35
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) **Fee:** $360.45 **Benefit:** 75% = $270.35
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) **Fee:** $598.75 **Benefit:** 75% = $449.10

37041	BLADDER ASPIRATION by needle **Fee:** $40.35 **Benefit:** 75% = $30.30 85% = $34.30
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:** $788.70 **Benefit:** 75% = $591.55
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:** $583.75 **Benefit:** 75% = $437.85
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:** $598.75 **Benefit:** 75% = $449.10
37045	MITROFANOFF CONTINENT VALVE, formation of (Anaes.) (Assist.) **Fee:** $1,236.55 **Benefit:** 75% = $927.45
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) **Fee:** $1,441.90 **Benefit:** 75% = $1,081.45
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
	OPERATIONS ON THE PROSTATE
37200	PROSTATECTOMY, open (Anaes.) (Assist.) **Fee:** $879.60 **Benefit:** 75% = $659.70
37201	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or cold punch) and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) *(See para T8.52 of explanatory notes to this Category)* **Fee:** $717.40 **Benefit:** 75% = $538.05
37202	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37203,37207, 37201 which had to be discontinued for medical reasons (Anaes.) *(See para T8.52 of explanatory notes to this Category)* **Fee:** $360.05 **Benefit:** 75% = $270.05 85% = $306.05
37203	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $901.90 **Benefit:** 75% = $676.45
37206	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37208 or which had to be discontinued for medical reasons (Anaes.) **Fee:** $483.00 **Benefit:** 75% = $362.25
37207	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37202, 37203, 37206, 37321 or 37324 applies (Anaes.) **Fee:** $749.90 **Benefit:** 75% = $562.45
37208	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37203, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by items 37201, 37203, 37207 or which had to be discontinued for medical reasons (Anaes.) **Fee:** $360.05 **Benefit:** 75% = $270.05

37209	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.) **Fee:** $1,117.45 **Benefit:** 75% = $838.10
37210	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.) **Fee:** $1,379.05 **Benefit:** 75% = $1,034.30
37211	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, ***with pelvic lymphadenectomy***, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.) **Fee:** $1,674.90 **Benefit:** 75% = $1,256.20
37212	PROSTATE, open perineal biopsy or open drainage of abscess (Anaes.) (Assist.) **Fee:** $239.35 **Benefit:** 75% = $179.55
37215	PROSTATE, biopsy of, endoscopic, with or without cystoscopy (Anaes.) (Assist.) **Fee:** $360.45 **Benefit:** 75% = $270.35 85% = $306.40
37218	PROSTATE, needle biopsy of, or injection into (Anaes.) **Fee:** $119.70 **Benefit:** 75% = $89.80 85% = $101.75
37219	PROSTATE, transrectal needle biopsy of, using transrectal prostatic ultrasound techniques and obtaining 1 or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.) (Assist.) **Fee:** $243.05 **Benefit:** 75% = $182.30 85% = $206.60
I 37220	PROSTATE, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 6 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies. *(See para T8.54 of explanatory notes to this Category)* **Fee:** $903.70 **Benefit:** 75% = $677.80
37221	PROSTATIC ABSCESS, endoscopic drainage of (Anaes.) (Assist.) **Fee:** $403.60 **Benefit:** 75% = $302.70
37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.) **Fee:** $178.50 **Benefit:** 75% = $133.90
37224	PROSTATE, diathermy or visual laser destruction of lesion of, not being a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.) **Fee:** $279.75 **Benefit:** 75% = $209.85 85% = $237.80
	OPERATIONS ON URETHRA, PENIS OR SCROTUM
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) **Fee:** $40.35 **Benefit:** 75% = $30.30 85% = $34.30
37303	URETHRAL STRICTURE, dilatation of (Anaes.) **Fee:** $64.10 **Benefit:** 75% = $48.10 85% = $54.50
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) **Fee:** $562.40 **Benefit:** 75% = $421.80
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
37315	URETHROSCOPY, as an independent procedure (Anaes.) **Fee:** $119.70 **Benefit:** 75% = $89.80 85% = $101.75
37318	URETHROSCOPY with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes.) (Assist.) **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45
37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.) **Fee:** $80.75 **Benefit:** 75% = $60.60 85% = $68.65

37324	URETHROTOMY OR URETHROSTOMY, internal or external (Anaes.) **Fee:** $198.95 **Benefit:** 75% = $149.25
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) **Fee:** $279.75 **Benefit:** 75% = $209.85
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) **Fee:** $562.40 **Benefit:** 75% = $421.80
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $483.00 **Benefit:** 75% = $362.25
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
37339	PERIURETHRAL OR TRANSURETHRAL INJECTION of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy (Anaes.) **Fee:** $207.60 **Benefit:** 75% = $155.70 85% = $176.50
37340	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, vaginal approach, not being a service associated with a service to which item number 37341 applies (Anaes.) (Assist.) **Fee:** $367.80 **Benefit:** 75% = $275.85
37341	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined suprapubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Anaes.) (Assist.) **Fee:** $788.70 **Benefit:** 75% = $591.55
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.) **Fee:** $721.00 **Benefit:** 75% = $540.75
37343	URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.) **Fee:** $1,204.00 **Benefit:** 75% = $903.00
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) **Fee:** $598.40 **Benefit:** 75% = $448.80
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) **Fee:** $598.40 **Benefit:** 75% = $448.80
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $239.35 **Benefit:** 75% = $179.55
37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.) **Fee:** $279.75 **Benefit:** 75% = $209.85
37369	URETHRA, excision of prolapse of (Anaes.) **Fee:** $161.45 **Benefit:** 75% = $121.10
37372	URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.) **Fee:** $403.60 **Benefit:** 75% = $302.70
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) **Fee:** $1,002.05 **Benefit:** 75% = $751.55
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) **Fee:** $1,002.05 **Benefit:** 75% = $751.55
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) **Fee:** $279.75 **Benefit:** 75% = $209.85

37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
37393	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.) **Fee:** $198.95 **Benefit:** 75% = $149.25 85% = $169.15
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35
37402	PENIS, partial amputation of (Anaes.) (Assist.) **Fee:** $403.60 **Benefit:** 75% = $302.70
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) **Fee:** $403.60 **Benefit:** 75% = $302.70
37411	PENIS, repair of avulsion (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20 85% = $738.75
37415	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months **Fee:** $40.35 **Benefit:** 75% = $30.30 85% = $34.30
37417	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes.) (Assist.) **Fee:** $483.00 **Benefit:** 75% = $362.25
37418	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilization of the urethra (Anaes.) (Assist.) **Fee:** $641.75 **Benefit:** 75% = $481.35 85% = $580.25
37420	PENIS, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins with or without pharmacological erection test (Anaes.) (Assist.) **Fee:** $317.15 **Benefit:** 75% = $237.90
37423	PENIS, lengthening by translocation of corpora (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) **Fee:** $843.45 **Benefit:** 75% = $632.60
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) **Fee:** $279.75 **Benefit:** 75% = $209.85
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
37435	PENIS, frenuloplasty as an independent procedure (Anaes.) **Fee:** $80.75 **Benefit:** 75% = $60.60 85% = $68.65
37438	SCROTUM, partial excision of (Anaes.) (Assist.) **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45
37444	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.) **Fee:** $865.15 **Benefit:** 75% = $648.90 85% = $803.65
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45
37604	EXPLORATION OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45

37607	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (Anaes.) (Assist.) **Fee:** $800.25 **Benefit:** 75% = $600.20
37610	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (Anaes.) (Assist.) **Fee:** $1,204.00 **Benefit:** 75% = $903.00
37613	EPIDIDYMECTOMY (Anaes.) **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, for other than reversal of previous elective sterilisation, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) *(See para T8.49 of explanatory notes to this Category)* **Fee:** $598.40 **Benefit:** 75% = $448.80
37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, for other than reversal of previous elective sterilisation, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) *(See para T8.49 of explanatory notes to this Category)* **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45
37622 G 37623 S	VASOTOMY OR VASECTOMY, unilateral or bilateral **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $167.25 **Benefit:** 75% = $125.45 85% = $142.20 **Fee:** $198.95 **Benefit:** 75% = $149.25 85% = $169.15
	PAEDIATRIC GENITOURINARY SURGERY
37800	PATENT URACHUS, excision of (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Anaes.) (Assist.) **Fee:** $521.20 **Benefit:** 75% = $390.90 85% = $459.70
37809	UNDESCENDED TESTIS, revision orchidopexy for (Anaes.) (Assist.) **Fee:** $521.20 **Benefit:** 75% = $390.90
37812	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803 to 37809 applies (Anaes.) (Assist.) **Fee:** $481.25 **Benefit:** 75% = $360.95
37815	HYPOSPADIAS, examination under anaesthesia with erection test (Anaes.) **Fee:** $80.20 **Benefit:** 75% = $60.15
37818	HYPOSPADIAS, glanuloplasty incorporating meatal advancement (Anaes.) (Assist.) **Fee:** $425.35 **Benefit:** 75% = $319.05 85% = $363.85
37821	HYPOSPADIAS, distal, 1 stage repair (Anaes.) (Assist.) **Fee:** $721.00 **Benefit:** 75% = $540.75
37824	HYPOSPADIAS, proximal, 1 stage repair (Anaes.) (Assist.) **Fee:** $1,002.50 **Benefit:** 75% = $751.90
37827	HYPOSPADIAS, staged repair, first stage (Anaes.) (Assist.) **Fee:** $461.80 **Benefit:** 75% = $346.35
37830	HYPOSPADIAS, staged repair, second stage (Anaes.) (Assist.) **Fee:** $598.40 **Benefit:** 75% = $448.80 85% = $536.90

37833	HYPOSPADIAS, repair of post operative urethral fistula (Anaes.) (Assist.) **Fee:** $285.60 **Benefit:** 75% = $214.20
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) **Fee:** $601.55 **Benefit:** 75% = $451.20
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) **Fee:** $681.65 **Benefit:** 75% = $511.25
37842	EXSTROPHY OF BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) **Fee:** $1,323.40 **Benefit:** 75% = $992.55
37845	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.) **Fee:** $601.55 **Benefit:** 75% = $451.20
37848	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
37851	CONGENITAL ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) **Fee:** $802.10 **Benefit:** 75% = $601.60
37854	URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.) **Fee:** $317.15 **Benefit:** 75% = $237.90
	SUBGROUP 6 - CARDIO-THORACIC
	CARDIOLOGY PROCEDURES
38200	RIGHT HEART CATHETERISATION, including fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection and exercise stress test (Anaes.) **Fee:** $385.50 **Benefit:** 75% = $289.15 85% = $327.70
38203	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture including fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection and exercise stress test (Anaes.) **Fee:** $460.00 **Benefit:** 75% = $345.00 85% = $398.50
38206	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure including fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection and exercise stress test (Anaes.) **Fee:** $556.15 **Benefit:** 75% = $417.15 85% = $494.65
38209	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $714.05 **Benefit:** 75% = $535.55 85% = $652.55
38212	CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation not being a service associated with a service to which item 38209 or 38213 applies (Anaes.) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $1,187.80 **Benefit:** 75% = $890.85 85% = $1,126.30
38213	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes.) **Fee:** $353.70 **Benefit:** 75% = $265.30 85% = $300.65

38215	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $383.95	**Benefit:** 75% = $288.00	85% = $326.40
38218	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $575.85	**Benefit:** 75% = $431.90	85% = $514.35
38220	SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $191.95	**Benefit:** 75% = $144.00	85% = $163.20
38222	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $383.95	**Benefit:** 75% = $288.00	85% = $326.40
38225	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $575.90	**Benefit:** 75% = $431.95	85% = $514.40
38228	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $767.90	**Benefit:** 75% = $575.95	85% = $706.40
38231	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $959.85	**Benefit:** 75% = $719.90	85% = $898.35
38234	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $767.85	**Benefit:** 75% = $575.90	85% = $706.35
38237	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $959.80	**Benefit:** 75% = $719.85	85% = $898.30

38240	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $1,151.70 **Benefit:** 75% = $863.80 85% = $1,090.20
38243	PLACEMENT OF CATHETER(S) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $383.95 **Benefit:** 75% = $288.00 85% = $326.40
38246	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $959.80 **Benefit:** 75% = $719.85 85% = $898.30
38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.) **Fee:** $231.25 **Benefit:** 75% = $173.45 85% = $196.60
38270	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.) **Fee:** $789.55 **Benefit:** 75% = $592.20 85% = $728.05
* 38272	ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.) **Fee:** $789.55 **Benefit:** 75% = $592.20 85% = $728.05
38275	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.) **Fee:** $258.10 **Benefit:** 75% = $193.60 85% = $219.40
38285	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where: - a diagnosis has not been achieved through all other available cardiac investigations; and - a neurogenic cause is not suspected; and - it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death. including initial programming and testing, as an admitted patient in an approved hospital or day-hospital facility (Anaes.) *(See para T8.57 of explanatory notes to this Category)* **Fee:** $166.95 **Benefit:** 75% = $125.25 85% = $141.95
38286	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital or day-hospital facility (Anaes.) **Fee:** $150.35 **Benefit:** 75% = $112.80 85% = $127.80
	CATHETER BASED ARRHYTHMIA ABLATION
38287	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.) **Fee:** $1,816.05 **Benefit:** 75% = $1,362.05 85% = $1,754.55
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.) **Fee:** $2,312.50 **Benefit:** 75% = $1,734.40
38293	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.) **Fee:** $2,482.15 **Benefit:** 75% = $1,861.65 85% = $2,420.65
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
* 38300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $446.10 **Benefit:** 75% = $334.60 85% = $384.60

* 38303	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes.) (Assist.) **Fee:** $571.90 **Benefit:** 75% = $428.95 85% = $510.40
* 38306	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $659.85 **Benefit:** 75% = $494.90 85% = $598.35
* 38309	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $766.35 **Benefit:** 75% = $574.80 85% = $704.85
* 38312	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $980.05 **Benefit:** 75% = $735.05 85% = $918.55
* 38315	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $1,052.25 **Benefit:** 75% = $789.20 85% = $990.75
* 38318	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $1,372.90 **Benefit:** 75% = $1,029.70 85% = $1,311.40
* 38321	CATHETER BASED INTRAVASCULAR BRACHYTHERAPY treatment of in-stent restenoses in 1 coronary artery, catheterisation for, including in the same artery; - balloon angioplasty using automated intravascular brachytherapy systems approved by the Therapeutic Goods Administration, excluding associated radiological services or preparation, and excluding aftercare. The procedure must be performed by a cardiologist in association with a radiation oncologist, and be associated with a service to which item 15360, 15363 or 15541 applies. (Anaes.) (Assist.) *(See para T8.41 of explanatory notes to this Category)* **Fee:** $669.10 **Benefit:** 75% = $501.85 85% = $607.60
* 38324	CATHETER BASED INTRAVASCULAR BRACHYTHERAPY treatment of in-stent restenoses in 1 coronary artery, catheterisation for, including in the same artery; - balloon angioplasty - intravascular ultrasound using automated intravascular brachytherapy systems approved by the Therapeutic Goods Administration, excluding associated radiological services or preparation, and excluding aftercare. The procedure must be performed by a cardiologist in association with a radiation oncologist, and be associated with a service to which item 15360, 15363 or 15541 applies. (Anaes.) (Assist.) *(See para T8.41 of explanatory notes to this Category)* **Fee:** $891.50 **Benefit:** 75% = $668.65 85% = $830.00

* 38327	CATHETER BASED INTRAVASCULAR BRACHYTHERAPY treatment of in-stent restenoses in 1 coronary artery, catheterisation for, including in the same artery; - balloon angioplasty - percutaneous transluminal rotational artherectomy using automated intravascular brachytherapy systems approved by the Therapeutic Goods Administration, excluding associated radiological services or preparation, and excluding aftercare. The procedure must be performed by a cardiologist in association with a radiation oncologist, and be associated with a service to which item 15360, 15363 or 15541 applies. (Anaes.) (Assist.) *(See para T8.41 of explanatory notes to this Category)* **Fee:** $989.35 **Benefit:** 75% = $742.05 85% = $927.85
* 38330	CATHETER BASED INTRAVASCULAR BRACHYTHERAPY treatment of in-stent restenoses in 1 coronary artery, catheterisation for, including in the same artery; - balloon angioplasty - percutaneous transluminal rotational artherectomy - intravascular ultrasound using automated intravascular brachytherapy systems approved by the Therapeutic Goods Administration, excluding associated radiological services or preparation, and excluding aftercare. The procedure must be performed by a cardiologist in association with a radiation oncologist, and be associated with a service to which item 15360, 15363 or 15541 applies. (Anaes.) (Assist.) *(See para T8.41 of explanatory notes to this Category)* **Fee:** $1,212.40 **Benefit:** 75% = $909.30 85% = $1,150.90
	MISCELLANEOUS CARDIAC PROCEDURES
* 38350	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of (Anaes.) **Fee:** $552.80 **Benefit:** 75% = $414.60
* 38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of (Anaes.) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $221.10 **Benefit:** 75% = $165.85
* 38356	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of (Anaes.) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $724.70 **Benefit:** 75% = $543.55
H 38358	Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Anaes.) (Assist.) *(See para T8.58 of explanatory notes to this Category)* **Fee:** $2,482.15 **Benefit:** 75% = $1,861.65
* 38359	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.) **Fee:** $115.60 **Benefit:** 75% = $86.70 85% = $98.30
* 38362	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.) **Fee:** $333.10 **Benefit:** 75% = $249.85 85% = $283.15
I * 38390	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $911.05 **Benefit:** 75% = $683.30 85% = $849.55
* 38393	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of - not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $249.10 **Benefit:** 75% = $186.85 85% = $211.75
38415	EMPYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.) **Fee:** $345.60 **Benefit:** 75% = $259.20 85% = $293.80
38418	THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.) **Fee:** $829.50 **Benefit:** 75% = $622.15
38421	THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.) **Fee:** $1,325.90 **Benefit:** 75% = $994.45
38424	THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.) **Fee:** $829.50 **Benefit:** 75% = $622.15

38427	THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.) **Fee:** $1,024.20 **Benefit:** 75% = $768.15
38430	THORACOPLASTY (in stages) each stage (Anaes.) (Assist.) **Fee:** $527.85 **Benefit:** 75% = $395.90
38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.) **Fee:** $216.15 **Benefit:** 75% = $162.15
38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes.) (Assist.) **Fee:** $1,325.90 **Benefit:** 75% = $994.45
38440	LUNG, wedge resection of (Anaes.) (Assist.) **Fee:** $992.85 **Benefit:** 75% = $744.65
38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.) **Fee:** $1,570.95 **Benefit:** 75% = $1,178.25
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.) **Fee:** $1,024.20 **Benefit:** 75% = $768.15
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,325.90 **Benefit:** 75% = $994.45
38448	MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.) **Fee:** $314.20 **Benefit:** 75% = $235.65
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,854.90 **Benefit:** 75% = $1,391.20
I 38450	PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.) **Fee:** $741.45 **Benefit:** 75% = $556.10
38452	PERICARDIUM, sub-xyphoid drainage of (Anaes.) (Assist.) **Fee:** $496.50 **Benefit:** 75% = $372.40
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,489.35 **Benefit:** 75% = $1,117.05
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $2,014.55 **Benefit:** 75% = $1,510.95
38456	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,325.90 **Benefit:** 75% = $994.45
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.) **Fee:** $1,237.85 **Benefit:** 75% = $928.40
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.) **Fee:** $659.85 **Benefit:** 75% = $494.90
38460	STERNAL WIRE OR WIRES, removal of (Anaes.) **Fee:** $238.35 **Benefit:** 75% = $178.80
38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes.) **Fee:** $282.45 **Benefit:** 75% = $211.85
38464	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.) **Fee:** $307.05 **Benefit:** 75% = $230.30

38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.) **Fee:** $829.15 **Benefit:** 75% = $621.90
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.) **Fee:** $1,277.60 **Benefit:** 75% = $958.20
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.) **Fee:** $1,489.35 **Benefit:** 75% = $1,117.05
	CARDIAC SURGERY PROCEDURES
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.) **Fee:** $829.50 **Benefit:** 75% = $622.15
I 38473	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.) **Fee:** $496.50 **Benefit:** 75% = $372.40
	VALVULAR PROCEDURES
38475	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.) **Fee:** $719.90 **Benefit:** 75% = $539.95
38477	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.) **Fee:** $1,733.85 **Benefit:** 75% = $1,300.40
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.) **Fee:** $839.90 **Benefit:** 75% = $629.95
38480	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.) **Fee:** $1,733.85 **Benefit:** 75% = $1,300.40
38481	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.) **Fee:** $1,973.85 **Benefit:** 75% = $1,480.40
38483	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assist.) **Fee:** $1,489.35 **Benefit:** 75% = $1,117.05
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) **Fee:** $707.20 **Benefit:** 75% = $530.40
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) **Fee:** $1,489.35 **Benefit:** 75% = $1,117.05
38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.) **Fee:** $1,652.70 **Benefit:** 75% = $1,239.55
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.) **Fee:** $1,965.50 **Benefit:** 75% = $1,474.15
38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.) **Fee:** $479.90 **Benefit:** 75% = $359.95
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) **Fee:** $1,694.25 **Benefit:** 75% = $1,270.70
	SURGERY FOR ISCHAEMIC HEART DISEASE
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.) **Fee:** $540.00 **Benefit:** 75% = $405.00

38497	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service asociated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.) *(See para T8.59 of explanatory notes to this Category)* **Fee:** $1,772.10 **Benefit:** 75% = $1,329.10
38498	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.) *(See para T8.59 of explanatory notes to this Category)* **Fee:** $1,772.10 **Benefit:** 75% = $1,329.10
38500	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Anaes.) (Assist.) *(See para T8.59 of explanatory notes to this Category)* **Fee:** $1,904.00 **Benefit:** 75% = $1,428.00
38501	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38503, 38504 or 38600 apply (Anaes.) (Assist.) *(See para T8.59 of explanatory notes to this Category)* **Fee:** $1,904.00 **Benefit:** 75% = $1,428.00
38503	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Anaes.) (Assist.) *(See para T8.59 of explanatory notes to this Category)* **Fee:** $2,067.35 **Benefit:** 75% = $1,550.55
38504	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Anaes.) (Assist.) *(See para T8.59 of explanatory notes to this Category)* **Fee:** $2,067.35 **Benefit:** 75% = $1,550.55
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.) (Assist.) **Fee:** $239.95 **Benefit:** 75% = $180.00
38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.) **Fee:** $1,407.50 **Benefit:** 75% = $1,055.65
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.) **Fee:** $1,652.35 **Benefit:** 75% = $1,239.30
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.) **Fee:** $2,067.35 **Benefit:** 75% = $1,550.55
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.) **Fee:** $2,067.35 **Benefit:** 75% = $1,550.55
	ARRHYTHMIA SURGERY
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.) **Fee:** $1,816.05 **Benefit:** 75% = $1,362.05
38515	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes.) (Assist.) **Fee:** $2,312.50 **Benefit:** 75% = $1,734.40

38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.) **Fee:** $2,482.15 **Benefit:** 75% = $1,861.65
	PROCEDURES ON THE THORACIC AORTA
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) **Fee:** $1,857.45 **Benefit:** 75% = $1,393.10
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) **Fee:** $2,353.85 **Benefit:** 75% = $1,765.40
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) **Fee:** $2,687.00 **Benefit:** 75% = $2,015.25
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) **Fee:** $2,190.50 **Benefit:** 75% = $1,642.90
38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) **Fee:** $2,687.00 **Benefit:** 75% = $2,015.25
38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) **Fee:** $3,013.70 **Benefit:** 75% = $2,260.30
38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,612.30 **Benefit:** 75% = $1,209.25
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,775.70 **Benefit:** 75% = $1,331.80
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.) **Fee:** $1,719.75 **Benefit:** 75% = $1,289.85
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.) **Fee:** $479.90 **Benefit:** 75% = $359.95
	TECHNIQUES FOR PRESERVATION OF THE ARRESTED HEART
38588	CANNULATION of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.) **Fee:** $360.05 **Benefit:** 75% = $270.05
	CIRCULATORY SUPPORT PROCEDURES
38600	CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $1,325.90 **Benefit:** 75% = $994.45
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes.) (Assist.) **Fee:** $829.50 **Benefit:** 75% = $622.15
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.) **Fee:** $414.70 **Benefit:** 75% = $311.05
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.) **Fee:** $464.85 **Benefit:** 75% = $348.65 85% = $403.35
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.) **Fee:** $583.45 **Benefit:** 75% = $437.60

38615	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) **Fee:** $1,325.90 **Benefit:** 75% = $994.45
38618	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) **Fee:** $1,652.70 **Benefit:** 75% = $1,239.55
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $659.85 **Benefit:** 75% = $494.90
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $741.45 **Benefit:** 75% = $556.10
38627	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR VENTRICULAR ASSIST DEVICE CANNULAE, adjustment and re-positioning of, by open operation, in patients supported by these devices (Anaes.) (Assist.) **Fee:** $579.50 **Benefit:** 75% = $434.65
	RE-OPERATION
38637	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.) **Fee:** $479.90 **Benefit:** 75% = $359.95
38640	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes.) (Assist.) *(See para T8.60 of explanatory notes to this Category)* **Fee:** $829.50 **Benefit:** 75% = $622.15
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES
38643	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) **Fee:** $923.75 **Benefit:** 75% = $692.85
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38650	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.) **Fee:** $1,652.70 **Benefit:** 75% = $1,239.55
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,652.70 **Benefit:** 75% = $1,239.55
38656	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.) **Fee:** $829.50 **Benefit:** 75% = $622.15
	CARDIAC TUMOURS
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.) **Fee:** $1,652.35 **Benefit:** 75% = $1,239.30
38673	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.) **Fee:** $1,859.80 **Benefit:** 75% = $1,394.85
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.) **Fee:** $1,739.85 **Benefit:** 75% = $1,304.90
38680	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.) **Fee:** $2,063.75 **Benefit:** 75% = $1,547.85 85% = $2,002.25
	CONGENITAL CARDIAC SURGERY
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $923.75 **Benefit:** 75% = $692.85

38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,665.25 **Benefit:** 75% = $1,248.95
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,577.25 **Benefit:** 75% = $1,182.95
38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.) **Fee:** $2,218.30 **Benefit:** 75% = $1,663.75
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,476.75 **Benefit:** 75% = $1,107.60
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,294.50 **Benefit:** 75% = $970.90
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38727	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,294.50 **Benefit:** 75% = $970.90
38730	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,294.50 **Benefit:** 75% = $970.90
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,665.25 **Benefit:** 75% = $1,248.95
38742	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,665.25 **Benefit:** 75% = $1,248.95
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38751	VENTRICULAR SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) **Fee:** $2,312.50 **Benefit:** 75% = $1,734.40
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55

38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.) **Fee:** $1,847.35 **Benefit:** 75% = $1,385.55
	MISCELLANEOUS PROCEDURES ON THE CHEST
* 38800	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38403 applies **Fee:** $33.35 **Benefit:** 75% = $25.05 85% = $28.35
* 38803	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample **Fee:** $66.50 **Benefit:** 75% = $49.90 85% = $56.55
* 38806	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $115.60 **Benefit:** 75% = $86.70 85% = $98.30
* 38809	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $142.45 **Benefit:** 75% = $106.85 85% = $121.10
* 38812	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) **Fee:** $181.05 **Benefit:** 75% = $135.80 85% = $153.90
	SUBGROUP 7 - NEUROSURGICAL
	GENERAL
39000	LUMBAR PUNCTURE (Anaes.) **Fee:** $65.20 **Benefit:** 75% = $48.90 85% = $55.45
39003	CISTERNAL PUNCTURE (Anaes.) **Fee:** $74.15 **Benefit:** 75% = $55.65 85% = $63.05
39006	VENTRICULAR PUNCTURE (not including burr-hole) (Anaes.) **Fee:** $138.00 **Benefit:** 75% = $103.50 85% = $117.30
39009	SUBDURAL HAEMORRHAGE, tap for, each tap (Anaes.) **Fee:** $51.35 **Benefit:** 75% = $38.55
39012	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.) **Fee:** $205.65 **Benefit:** 75% = $154.25
39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.) **Fee:** $94.50 **Benefit:** 75% = $70.90 85% = $80.35
39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.) (Assist.) **Fee:** $325.40 **Benefit:** 75% = $244.05
39018	CEREBROSPINAL FLUID reservoir, insertion of (Anaes.) (Assist.) **Fee:** $325.40 **Benefit:** 75% = $244.05
	PROCEDURES FOR PAIN RELIEF
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) **Fee:** $205.65 **Benefit:** 75% = $154.25 85% = $174.85
39106	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.) **Fee:** $1,028.35 **Benefit:** 75% = $771.30
39109	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.) **Fee:** $384.00 **Benefit:** 75% = $288.00 85% = $326.40

39112	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,334.20 **Benefit:** 75% = $1,000.65
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.) **Fee:** $65.20 **Benefit:** 75% = $48.90 85% = $55.45
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.) **Fee:** $257.75 **Benefit:** 75% = $193.35 85% = $219.10
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) **Fee:** $546.75 **Benefit:** 75% = $410.10 85% = $485.25
39124	CORDOTOMY OR MYELOTOMY, laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) **Fee:** $1,399.25 **Benefit:** 75% = $1,049.45
39125	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $257.95 **Benefit:** 75% = $193.50
39126	INFUSION PUMP, subcutaneous implantation or replacement of, and connection of the pump to an intrathecal or epidural catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $313.20 **Benefit:** 75% = $234.90
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic intractable pain (Anaes.) **Fee:** $409.95 **Benefit:** 75% = $307.50
39128	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $571.15 **Benefit:** 75% = $428.40
39130	EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) **Fee:** $583.50 **Benefit:** 75% = $437.65
39131	ELECTRODES, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris - each day **Fee:** $110.65 **Benefit:** 75% = $83.00 85% = $94.10
39133	Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of chronic intractable pain (Anaes.) **Fee:** $138.00 **Benefit:** 75% = $103.50
39134	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.) **Fee:** $294.80 **Benefit:** 75% = $221.10
39135	NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital or approved day hospital facility (Anaes.) **Fee:** $138.00 **Benefit:** 75% = $103.50 85% = $117.30
39136	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital or approved day hospital facility (Anaes.) **Fee:** $138.00 **Benefit:** 75% = $103.50
39137	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain from refractory angina pectoris, surgical repositioning to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, not being a service to which item 39130, 39138 or 39139 applies (Anaes.) **Fee:** $523.95 **Benefit:** 75% = $393.00

I 39138	PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (Assist.) **Fee:** $583.50 **Benefit:** 75% = $437.65
39139	EPIDURAL LEAD, surgical placement of one or more by laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.) **Fee:** $783.30 **Benefit:** 75% = $587.50
39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) **Fee:** $253.45 **Benefit:** 75% = $190.10 85% = $215.45
	PERIPHERAL NERVES
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $305.85 **Benefit:** 75% = $229.40
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $403.40 **Benefit:** 75% = $302.55
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $585.80 **Benefit:** 75% = $439.35
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $618.20 **Benefit:** 75% = $463.65
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $344.90 **Benefit:** 75% = $258.70
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) **Fee:** $891.60 **Benefit:** 75% = $668.70
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $553.20 **Benefit:** 75% = $414.90
39321	NERVE, transposition of (Anaes.) (Assist.) **Fee:** $409.95 **Benefit:** 75% = $307.50
39323	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.) **Fee:** $239.50 **Benefit:** 75% = $179.65 85% = $203.60
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.) **Fee:** $239.50 **Benefit:** 75% = $179.65 85% = $203.60
39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve, by open operation (Anaes.) (Assist.) **Fee:** $409.95 **Benefit:** 75% = $307.50
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.) **Fee:** $239.50 **Benefit:** 75% = $179.65
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.) **Fee:** $239.50 **Benefit:** 75% = $179.65 85% = $203.60
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $344.90 **Benefit:** 75% = $258.70 85% = $293.20
	CRANIAL NERVES
39500	VESTIBULAR NERVE, section of, via posterior fossa (Anaes.) (Assist.) **Fee:** $1,099.95 **Benefit:** 75% = $825.00
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.) **Fee:** $826.50 **Benefit:** 75% = $619.90

	CRANIO-CEREBRAL INJURIES
39600	INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes (Anaes.) (Assist.) **Fee:** $409.95 **Benefit:** 75% = $307.50
39603	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes.) (Assist.) **Fee:** $1,034.80 **Benefit:** 75% = $776.10
39606	FRACTURED SKULL, depressed or comminuted, operation for (Anaes.) (Assist.) **Fee:** $689.85 **Benefit:** 75% = $517.40
39609	FRACTURED SKULL, compound, without dural penetration, operation for (Anaes.) (Assist.) **Fee:** $826.50 **Benefit:** 75% = $619.90
39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.) (Assist.) **Fee:** $969.75 **Benefit:** 75% = $727.35
39615	FRACTURED SKULL with rhinorrhoea or otorrhoea, cranioplasty and repair of (Anaes.) (Assist.) **Fee:** $1,034.80 **Benefit:** 75% = $776.10
	SKULL BASE SURGERY
39640	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes.) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $2,623.80 **Benefit:** 75% = $1,967.85
39642	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes.) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $2,758.45 **Benefit:** 75% = $2,068.85
39646	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes.) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $3,162.05 **Benefit:** 75% = $2,371.55
39650	TUMOUR INVOLVING MIDDLE CRANIAL FOSSA AND INFRA-TEMPORAL FOSSA, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes.) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $2,287.35 **Benefit:** 75% = $1,715.55
39653	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or 39656 applies (Anaes.) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $4,070.35 **Benefit:** 75% = $3,052.80
39654	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Anaes.) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $2,960.30 **Benefit:** 75% = $2,220.25
39656	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure) conjoint surgery, co-surgeon (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $2,220.20 **Benefit:** 75% = $1,665.15
39658	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $2,623.80 **Benefit:** 75% = $1,967.85

39660	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $2,623.80 **Benefit:** 75% = $1,967.85
39662	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $2,623.80 **Benefit:** 75% = $1,967.85
	INTRACRANIAL NEOPLASMS
39700	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes.) (Assist.) **Fee:** $481.75 **Benefit:** 75% = $361.35
39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes.) (Assist.) **Fee:** $449.05 **Benefit:** 75% = $336.80
39706	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes.) (Assist.) **Fee:** $963.10 **Benefit:** 75% = $722.35
39709	CRANIOTOMY for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,373.25 **Benefit:** 75% = $1,029.95
39712	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $2,479.55 **Benefit:** 75% = $1,859.70
39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (Anaes.) (Assist.) **Fee:** $1,718.20 **Benefit:** 75% = $1,288.65
39718	ARACHNOIDAL CYST, craniotomy for (Anaes.) (Assist.) **Fee:** $754.95 **Benefit:** 75% = $566.25
39721	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes.) (Assist.) **Fee:** $689.85 **Benefit:** 75% = $517.40
	CEREBROVASCULAR DISEASE
39800	ANEURYSM, clipping or reinforcement of sac (Anaes.) (Assist.) **Fee:** $2,473.10 **Benefit:** 75% = $1,854.85
39803	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.) **Fee:** $2,473.10 **Benefit:** 75% = $1,854.85
39806	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.) **Fee:** $1,112.85 **Benefit:** 75% = $834.65
39812	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.) (Assist.) **Fee:** $546.75 **Benefit:** 75% = $410.10
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.) **Fee:** $1,581.45 **Benefit:** 75% = $1,186.10 85% = $1,519.95
39818	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.) **Fee:** $1,581.45 **Benefit:** 75% = $1,186.10
39821	EXTRACRANIAL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.) **Fee:** $1,877.85 **Benefit:** 75% = $1,408.40
	INFECTION
39900	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.) **Fee:** $449.05 **Benefit:** 75% = $336.80

39903	INTRACRANIAL ABSCESS, excision of (Anaes.) (Assist.) **Fee:** $1,373.25 **Benefit:** 75% = $1,029.95
39906	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.) **Fee:** $689.85 **Benefit:** 75% = $517.40
	CEREBRO-SPINAL FLUID CIRCULATION DISORDERS
40000	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.) **Fee:** $794.00 **Benefit:** 75% = $595.50
40003	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.) **Fee:** $794.00 **Benefit:** 75% = $595.50
40006	LUMBAR SHUNT DIVERSION, insertion of (Anaes.) (Assist.) **Fee:** $624.80 **Benefit:** 75% = $468.60
40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.) **Fee:** $455.55 **Benefit:** 75% = $341.70
40012	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.) (Assist.) **Fee:** $891.60 **Benefit:** 75% = $668.70
40015	SUBTEMPORAL DECOMPRESSION (Anaes.) (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.) **Fee:** $138.00 **Benefit:** 75% = $103.50 85% = $117.30
	CONGENITAL DISORDERS
40100	MENINGOCELE, excision and closure of (Anaes.) (Assist.) **Fee:** $598.75 **Benefit:** 75% = $449.10
40103	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (Anaes.) (Assist.) **Fee:** $878.65 **Benefit:** 75% = $659.00
40106	ARNOLD-CHIARI MALFORMATION, decompression of (Anaes.) (Assist.) **Fee:** $891.60 **Benefit:** 75% = $668.70
40109	ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.) **Fee:** $963.10 **Benefit:** 75% = $722.35
40112	TETHERED CORD, release of, including lipomeningocele or diastematomyelia (Anaes.) (Assist.) **Fee:** $1,236.55 **Benefit:** 75% = $927.45
40115	CRANIOSTENOSIS, operation for - single suture (Anaes.) (Assist.) **Fee:** $624.80 **Benefit:** 75% = $468.60
40118	CRANIOSTENOSIS, operation for - more than 1 suture (Anaes.) (Assist.) **Fee:** $826.50 **Benefit:** 75% = $619.90
	SPINAL DISORDERS
40300	INTERVERTEBRAL DISC OR DISCS, laminectomy for removal of (Anaes.) (Assist.) **Fee:** $826.50 **Benefit:** 75% = $619.90
40301	INTERVERTEBRAL DISC OR DISCS, microsurgical discectomy of (Anaes.) (Assist.) **Fee:** $829.15 **Benefit:** 75% = $621.90
40303	RECURRENT DISC LESION OR SPINAL STENOSIS, or both, laminectomy for - 1 level (Anaes.) (Assist.) **Fee:** $943.65 **Benefit:** 75% = $707.75
40306	SPINAL STENOSIS, laminectomy for, involving more than 1 vertebral interspace (disc level) (Anaes.) (Assist.) **Fee:** $1,243.05 **Benefit:** 75% = $932.30

40309	EXTRADURAL TUMOUR OR ABSCESS, laminectomy for (Anaes.) (Assist.) **Fee:** $943.65 **Benefit:** 75% = $707.75
40312	INTRADURAL LESION, laminectomy for, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,269.05 **Benefit:** 75% = $951.80
40315	CRANIOCERVICAL JUNCTION LESION, transoral approach for (Anaes.) (Assist.) **Fee:** $1,373.25 **Benefit:** 75% = $1,029.95
40316	ODONTOID screw fixation (Anaes.) (Assist.) **Fee:** $1,799.90 **Benefit:** 75% = $1,349.95
40318	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, laminectomy and radical excision of (Anaes.) (Assist.) **Fee:** $1,718.20 **Benefit:** 75% = $1,288.65
40321	POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (Anaes.) (Assist.) **Fee:** $943.65 **Benefit:** 75% = $707.75
40324	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - laminectomy, including aftercare (Anaes.) (Assist.) **Fee:** $553.20 **Benefit:** 75% = $414.90
40327	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - posterior fusion, including aftercare (Assist.) **Fee:** $553.20 **Benefit:** 75% = $414.90
40330	SPINAL RHIZOLYSIS involving exposure of spinal nerve roots - for lateral recess, exit foraminal stenosis, adhesive radiculopathy or extensive epidural fibrosis, at 1 or more levels - with or without laminectomy (Anaes.) (Assist.) **Fee:** $826.50 **Benefit:** 75% = $619.90
40331	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $826.50 **Benefit:** 75% = $619.90
40332	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, 1 level, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $1,348.70 **Benefit:** 75% = $1,011.55
40333	CERVICAL DISCECTOMY (ANTERIOR), without fusion (Anaes.) (Assist.) **Fee:** $689.85 **Benefit:** 75% = $517.40
40334	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $912.05 **Benefit:** 75% = $684.05
40335	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $1,675.10 **Benefit:** 75% = $1,256.35
40336	INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCASE) - 1 disc (Anaes.) (Assist.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $273.40 **Benefit:** 75% = $205.05
40339	HYDROMYELIA, plugging of obex for, with or without duroplasty (Anaes.) (Assist.) **Fee:** $1,373.25 **Benefit:** 75% = $1,029.95
40342	HYDROMYELIA, craniotomy and laminectomy for, with cavity packing and CSF shunt (Anaes.) (Assist.) **Fee:** $1,269.05 **Benefit:** 75% = $951.80
40345	THORACIC DECOMPRESSION of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Anaes.) (Assist.) **Fee:** $1,181.40 **Benefit:** 75% = $886.05
40348	THORACIC DECOMPRESSION of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes.) (Assist.) **Fee:** $1,499.90 **Benefit:** 75% = $1,124.95

40351	THORACO-LUMBAR or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Anaes.) (Assist.) **Fee:** $1,499.90 **Benefit:** 75% = $1,124.95
	SKULL RECONSTRUCTION
40600	CRANIOPLASTY, reconstructive (Anaes.) (Assist.) **Fee:** $826.50 **Benefit:** 75% = $619.90
	EPILEPSY
40700	CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes.) (Assist.) **Fee:** $1,509.95 **Benefit:** 75% = $1,132.50
40703	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.) **Fee:** $1,269.05 **Benefit:** 75% = $951.80
40706	HEMISPHERECTOMY for intractable epilepsy (Anaes.) (Assist.) **Fee:** $1,854.80 **Benefit:** 75% = $1,391.10 85% = $1,793.30
40709	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes.) (Assist.) **Fee:** $449.05 **Benefit:** 75% = $336.80
40712	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes.) (Assist.) **Fee:** $904.60 **Benefit:** 75% = $678.45
	STEREOTACTIC PROCEDURES ON THE HEAD
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes.) (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60 85% = $491.30
40801	FUNCTIONAL STEREOTACTIC procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts, not being a service associated with deep brain stimulation for Parkinson's disease (Anaes.) (Assist.) **Fee:** $1,510.90 **Benefit:** 75% = $1,133.20
40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes.) (Assist.) **Fee:** $1,034.80 **Benefit:** 75% = $776.10 85% = $973.30
	MISCELLANEOUS
40903	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.) **Fee:** $479.90 **Benefit:** 75% = $359.95
40905	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.) **Fee:** $520.70 **Benefit:** 75% = $390.55 85% = $459.20
	SUBGROUP 8 - EAR, NOSE AND THROAT
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) *(See para T8.63 of explanatory notes to this Category)* **Fee:** $71.40 **Benefit:** 75% = $53.55 85% = $60.70
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.) **Fee:** $206.70 **Benefit:** 75% = $155.05 85% = $175.70
41506	AURAL POLYP, removal of (Anaes.) **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.) **Fee:** $141.05 **Benefit:** 75% = $105.80 85% = $119.90

41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.) **Fee:** $507.15 **Benefit:** 75% = $380.40
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.) *(See para T8.64 of explanatory notes to this Category)* **Fee:** $332.80 **Benefit:** 75% = $249.60
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) **Fee:** $803.80 **Benefit:** 75% = $602.85
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.) **Fee:** $855.85 **Benefit:** 75% = $641.90
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.) *(See para T8.65 of explanatory notes to this Category)* **Fee:** $247.25 **Benefit:** 75% = $185.45
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.) **Fee:** $828.50 **Benefit:** 75% = $621.40
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $990.40 **Benefit:** 75% = $742.80
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,109.30 **Benefit:** 75% = $832.00
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $943.30 **Benefit:** 75% = $707.50
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.) **Fee:** $1,033.60 **Benefit:** 75% = $775.20
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) **Fee:** $598.75 **Benefit:** 75% = $449.10
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.) **Fee:** $1,378.75 **Benefit:** 75% = $1,034.10
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,624.40 **Benefit:** 75% = $1,218.30
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.) **Fee:** $943.30 **Benefit:** 75% = $707.50
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.) **Fee:** $1,033.60 **Benefit:** 75% = $775.20
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $1,279.55 **Benefit:** 75% = $959.70
41564	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes.) (Assist.) **Fee:** $1,654.65 **Benefit:** 75% = $1,241.00
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.) **Fee:** $943.30 **Benefit:** 75% = $707.50

41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.) **Fee:** $1,033.60 **Benefit:** 75% = $775.20
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) **Fee:** $894.15 **Benefit:** 75% = $670.65
41575	CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.) **Fee:** $2,108.05 **Benefit:** 75% = $1,581.05
41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.) **Fee:** $3,162.05 **Benefit:** 75% = $2,371.55
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,108.05 **Benefit:** 75% = $1,581.05
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,581.00 **Benefit:** 75% = $1,185.75
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) **Fee:** $2,424.65 **Benefit:** 75% = $1,818.50
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) **Fee:** $1,663.95 **Benefit:** 75% = $1,248.00
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) **Fee:** $2,266.25 **Benefit:** 75% = $1,699.70
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) **Fee:** $1,033.60 **Benefit:** 75% = $775.20
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) **Fee:** $1,347.10 **Benefit:** 75% = $1,010.35
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) **Fee:** $1,505.50 **Benefit:** 75% = $1,129.15
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) **Fee:** $1,505.50 **Benefit:** 75% = $1,129.15
41608	STAPEDECTOMY (Anaes.) (Assist.) **Fee:** $943.30 **Benefit:** 75% = $707.50
41611	STAPES MOBILISATION (Anaes.) (Assist.) **Fee:** $606.90 **Benefit:** 75% = $455.20
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.) **Fee:** $943.30 **Benefit:** 75% = $707.50 85% = $881.80
41615	OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.) **Fee:** $943.30 **Benefit:** 75% = $707.50 85% = $881.80
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,640.25 **Benefit:** 75% = $1,230.20
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) **Fee:** $713.60 **Benefit:** 75% = $535.20
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,033.60 **Benefit:** 75% = $775.20

41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.) **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.) **Fee:** $206.70 **Benefit:** 75% = $155.05 85% = $175.70
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $990.40 **Benefit:** 75% = $742.80 85% = $928.90
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,236.20 **Benefit:** 75% = $927.15
41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) **Fee:** $41.10 **Benefit:** 75% = $30.85 85% = $34.95
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) **Fee:** $123.55 **Benefit:** 75% = $92.70 85% = $105.05
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.) **Fee:** $95.10 **Benefit:** 75% = $71.35 85% = $80.85
41650	TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $95.10 **Benefit:** 75% = $71.35 85% = $80.85
41653	EXAMINATION OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND POSTNASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $62.25 **Benefit:** 75% = $46.70 85% = $52.95
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) **Fee:** $106.30 **Benefit:** 75% = $79.75 85% = $90.40
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) **Fee:** $67.15 **Benefit:** 75% = $50.40 85% = $57.10
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of *(See para T8.66 of explanatory notes to this Category)* **Fee:** $71.40 **Benefit:** 75% = $53.55 85% = $60.70
41665 G 41668 S	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes.) *(See para T8.66 of explanatory notes to this Category)* **Fee:** $149.30 **Benefit:** 75% = $112.00 **Fee:** $190.35 **Benefit:** 75% = $142.80
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.) **Fee:** $418.25 **Benefit:** 75% = $313.70
41672	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) **Fee:** $521.80 **Benefit:** 75% = $391.35
41674	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) **Fee:** $86.95 **Benefit:** 75% = $65.25 85% = $73.95
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $77.85 **Benefit:** 75% = $58.40 85% = $66.20
41680	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) **Fee:** $141.05 **Benefit:** 75% = $105.80 85% = $119.90

41683	DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the postoperative period of a nasal operation (Anaes.) **Fee:** $101.35 **Benefit:** 75% = $76.05 85% = $86.15
41686	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $62.25 **Benefit:** 75% = $46.70 85% = $52.95
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.) **Fee:** $118.10 **Benefit:** 75% = $88.60
41692	TURBINATES, submucous resection of, unilateral (Anaes.) **Fee:** $154.05 **Benefit:** 75% = $115.55
41695	TURBINATES, cryotherapy to (Anaes.) **Fee:** $86.55 **Benefit:** 75% = $64.95 85% = $73.60
41698	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $28.10 **Benefit:** 75% = $21.10 85% = $23.90
41701	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $79.60 **Benefit:** 75% = $59.70
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $31.45 **Benefit:** 75% = $23.60 85% = $26.75
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.) **Fee:** $388.20 **Benefit:** 75% = $291.15
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.) **Fee:** $524.95 **Benefit:** 75% = $393.75
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $255.90 **Benefit:** 75% = $191.95
41719	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $101.70 **Benefit:** 75% = $76.30 85% = $86.45
41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45 85% = $447.05
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.) **Fee:** $388.20 **Benefit:** 75% = $291.15
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.) **Fee:** $776.60 **Benefit:** 75% = $582.45
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.) **Fee:** $492.15 **Benefit:** 75% = $369.15
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.) **Fee:** $672.60 **Benefit:** 75% = $504.45
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.) **Fee:** $877.65 **Benefit:** 75% = $658.25
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.) **Fee:** $418.25 **Benefit:** 75% = $313.70
41740	FRONTAL SINUS, catheterisation of (Anaes.) **Fee:** $50.90 **Benefit:** 75% = $38.20

41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.) **Fee:** $292.05 **Benefit:** 75% = $219.05
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.) **Fee:** $672.60 **Benefit:** 75% = $504.45 85% = $611.10
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.) **Fee:** $524.95 **Benefit:** 75% = $393.75
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.) **Fee:** $255.90 **Benefit:** 75% = $191.95
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) **Fee:** $40.25 **Benefit:** 75% = $30.20 85% = $34.25
41758	DIVISION OF PHARYNGEAL ADHESIONS (Anaes.) **Fee:** $101.70 **Benefit:** 75% = $76.30 85% = $86.45
41761	POSTNASAL SPACE, direct examination of, with or without biopsy (Anaes.) **Fee:** $106.30 **Benefit:** 75% = $79.75 85% = $90.40
41764	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures (Anaes.) **Fee:** $106.30 **Benefit:** 75% = $79.75 85% = $90.40
41767	NASOPHARYNGEAL ANGIOFIBROMA, transpalatal removal (Anaes.) (Assist.) **Fee:** $637.80 **Benefit:** 75% = $478.35 85% = $576.30
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) **Fee:** $606.90 **Benefit:** 75% = $455.20
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.) **Fee:** $507.15 **Benefit:** 75% = $380.40
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) **Fee:** $606.90 **Benefit:** 75% = $455.20
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.) **Fee:** $824.00 **Benefit:** 75% = $618.00 85% = $762.50
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.) **Fee:** $1,022.25 **Benefit:** 75% = $766.70
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) **Fee:** $637.80 **Benefit:** 75% = $478.35
41787	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.) **Fee:** $492.15 **Benefit:** 75% = $369.15 85% = $430.65
41788 G 41789 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes.) **Fee:** $190.35 **Benefit:** 75% = $142.80 **Fee:** $255.90 **Benefit:** 75% = $191.95
41792 G 41793 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes.) **Fee:** $239.50 **Benefit:** 75% = $179.65 **Fee:** $321.55 **Benefit:** 75% = $241.20
41796 G 41797 S	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) **Fee:** $98.45 **Benefit:** 75% = $73.85 **Fee:** $124.65 **Benefit:** 75% = $93.50

41800 G 41801 S	ADENOIDS, removal of (Anaes.) **Fee:** $101.70 **Benefit:** 75% = $76.30 **Fee:** $141.05 **Benefit:** 75% = $105.80
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.) **Fee:** $77.85 **Benefit:** 75% = $58.40
41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) **Fee:** $60.70 **Benefit:** 75% = $45.55 85% = $51.60
41810	UVULOTOMY or UVULECTOMY (Anaes.) **Fee:** $30.80 **Benefit:** 75% = $23.10 85% = $26.20
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.) **Fee:** $160.70 **Benefit:** 75% = $120.55 85% = $136.60
41819	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope (Anaes.) **Fee:** $302.00 **Benefit:** 75% = $226.50 85% = $256.70
41820	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope, where the use of imaging intensification is clinically indicated (Anaes.) **Fee:** $362.45 **Benefit:** 75% = $271.85 85% = $308.10
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.) **Fee:** $206.70 **Benefit:** 75% = $155.05
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) **Fee:** $45.20 **Benefit:** 75% = $33.90 85% = $38.45
41831	OESOPHAGUS, endoscopic pneumatic dilatation of (Anaes.) (Assist.) **Fee:** $309.00 **Benefit:** 75% = $231.75 85% = $262.65
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) **Fee:** $197.75 **Benefit:** 75% = $148.35 85% = $168.10
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.) **Fee:** $1,115.65 **Benefit:** 75% = $836.75
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,069.75 **Benefit:** 75% = $802.35
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,315.35 **Benefit:** 75% = $986.55
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) **Fee:** $1,156.65 **Benefit:** 75% = $867.50
41846	LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes.) *(See para T8.67 of explanatory notes to this Category)* **Fee:** $160.70 **Benefit:** 75% = $120.55 85% = $136.60
41849	LARYNX, direct examination of, with biopsy (Anaes.) (Assist.) **Fee:** $236.20 **Benefit:** 75% = $177.15 85% = $200.80
41852	LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) **Fee:** $255.90 **Benefit:** 75% = $191.95

41855	MICROLARYNGOSCOPY (Anaes.) (Assist.) **Fee:** $249.45 **Benefit:** 75% = $187.10
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $427.70 **Benefit:** 75% = $320.80
41861	MICROLARYNGOSCOPY with removal of papillomata by laser surgery (Anaes.) (Assist.) **Fee:** $522.95 **Benefit:** 75% = $392.25
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) **Fee:** $352.70 **Benefit:** 75% = $264.55
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.) **Fee:** $530.85 **Benefit:** 75% = $398.15
41868	LARYNGEAL WEB, division of, using microlarygoscopic techniques (Anaes.) **Fee:** $336.45 **Benefit:** 75% = $252.35
41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.) **Fee:** $393.65 **Benefit:** 75% = $295.25
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45 85% = $447.05
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45 85% = $447.05
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.) **Fee:** $824.00 **Benefit:** 75% = $618.00
41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.) **Fee:** $219.95 **Benefit:** 75% = $165.00
41881	TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.) (Assist.) **Fee:** $347.65 **Benefit:** 75% = $260.75
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) **Fee:** $78.80 **Benefit:** 75% = $59.10
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $249.15 **Benefit:** 75% = $186.90 85% = $211.80
41886	TRACHEA, removal of foreign body in (Anaes.) **Fee:** $154.05 **Benefit:** 75% = $115.55 85% = $130.95
41889	BRONCHOSCOPY, as an independent procedure (Anaes.) **Fee:** $154.05 **Benefit:** 75% = $115.55 85% = $130.95
41892	BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) **Fee:** $203.45 **Benefit:** 75% = $152.60 85% = $172.95
41895	BRONCHUS, removal of foreign body in (Anaes.) (Assist.) **Fee:** $318.25 **Benefit:** 75% = $238.70
41898	FIBREOPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.) **Fee:** $222.40 **Benefit:** 75% = $166.80 85% = $189.05
41901	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $522.95 **Benefit:** 75% = $392.25

41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.) **Fee:** $213.30 **Benefit:** 75% = $160.00 85% = $181.35
41905	TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) **Fee:** $392.40 **Benefit:** 75% = $294.30
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) **Fee:** $106.30 **Benefit:** 75% = $79.75 85% = $90.40
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $337.70 **Benefit:** 75% = $253.30
	SUBGROUP 9 - OPHTHALMOLOGY
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $88.70 **Benefit:** 75% = $66.55
42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) **Fee:** $416.50 **Benefit:** 75% = $312.40 85% = $355.00
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) **Fee:** $527.15 **Benefit:** 75% = $395.40
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) **Fee:** $607.60 **Benefit:** 75% = $455.70
42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.) **Fee:** $416.50 **Benefit:** 75% = $312.40 85% = $355.00
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) **Fee:** $527.15 **Benefit:** 75% = $395.40
42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A MOTILITY INTEGRATING PEG by drilling into an existing orbital implant (Anaes.) (Assist.) **Fee:** $305.85 **Benefit:** 75% = $229.40
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) **Fee:** $1,041.35 **Benefit:** 75% = $781.05
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.) **Fee:** $177.05 **Benefit:** 75% = $132.80 85% = $150.50
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) **Fee:** $546.75 **Benefit:** 75% = $410.10
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) **Fee:** $722.35 **Benefit:** 75% = $541.80
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) **Fee:** $1,028.35 **Benefit:** 75% = $771.30
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $436.10 **Benefit:** 75% = $327.10
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $764.90 **Benefit:** 75% = $573.70

42545	ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.) (Assist.) **Fee:** $1,106.35 **Benefit:** 75% = $829.80
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) **Fee:** $657.30 **Benefit:** 75% = $493.00
42551	EYEBALL, PERFORATING WOUND OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.) (Assist.) **Fee:** $546.75 **Benefit:** 75% = $410.10 85% = $485.25
42554	EYEBALL, PERFORATING WOUND OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) **Fee:** $637.80 **Benefit:** 75% = $478.35
42557	EYEBALL, PERFORATING WOUND OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) **Fee:** $891.60 **Benefit:** 75% = $668.70
42560	INTRAOCULAR FOREIGN BODY, magnetic removal from anterior segment (Anaes.) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
42563	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from anterior segment (Anaes.) (Assist.) **Fee:** $449.05 **Benefit:** 75% = $336.80 85% = $387.55
42566	INTRAOCULAR FOREIGN BODY, magnetic removal from posterior segment (Anaes.) (Assist.) **Fee:** $637.80 **Benefit:** 75% = $478.35
42569	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from posterior segment (Anaes.) (Assist.) **Fee:** $891.60 **Benefit:** 75% = $668.70
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) **Fee:** $101.50 **Benefit:** 75% = $76.15 85% = $86.30
42573	DERMOID, periorbital, excision of (Anaes.) **Fee:** $196.85 **Benefit:** 75% = $147.65 85% = $167.35
42574	DERMOID, orbital, excision of (Anaes.) (Assist.) **Fee:** $418.25 **Benefit:** 75% = $313.70 85% = $356.75
42575	TARSAL CYST, extirpation of (Anaes.) **Fee:** $71.65 **Benefit:** 75% = $53.75 85% = $60.95
42578	TARSAL CARTILAGE, excision of (Anaes.) (Assist.) **Fee:** $403.40 **Benefit:** 75% = $302.55 85% = $342.90
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) **Fee:** $101.50 **Benefit:** 75% = $76.15 85% = $86.30
42584	TARSORRHAPHY (Anaes.) (Assist.) **Fee:** $239.50 **Benefit:** 75% = $179.65 85% = $203.60
42587	TRICHIASIS, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $44.95 **Benefit:** 75% = $33.75 85% = $38.25
42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) **Fee:** $292.80 **Benefit:** 75% = $219.60 85% = $248.90
42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes.) **Fee:** $177.05 **Benefit:** 75% = $132.80
42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) **Fee:** $436.10 **Benefit:** 75% = $327.10 85% = $374.60
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.) **Fee:** $546.75 **Benefit:** 75% = $410.10 85% = $485.25

42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) **Fee:** $546.75 **Benefit:** 75% = $410.10 85% = $485.25
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) **Fee:** $403.40 **Benefit:** 75% = $302.55 85% = $342.90
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30
42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $83.30 **Benefit:** 75% = $62.50 85% = $70.85
42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $124.95 **Benefit:** 75% = $93.75 85% = $106.25
42614	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, unilateral, including lavage, not being a service associated with a service to which item 42610 applies (excluding aftercare) **Fee:** $41.75 **Benefit:** 75% = $31.35 85% = $35.50
42615	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not being a service associated with a service to which item 42611 applies (excluding aftercare) **Fee:** $62.50 **Benefit:** 75% = $46.90 85% = $53.15
42617	PUNCTUM SNIP operation (Anaes.) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75
42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) **Fee:** $45.60 **Benefit:** 75% = $34.20 85% = $38.80
42621	PUNCTUM, temporary occlusion of, by use of electrical cautery (Anaes.) **Fee:** $45.60 **Benefit:** 75% = $34.20 85% = $38.80
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) **Fee:** $71.65 **Benefit:** 75% = $53.75 85% = $60.95
42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) **Fee:** $605.35 **Benefit:** 75% = $454.05
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.) **Fee:** $976.25 **Benefit:** 75% = $732.20 85% = $914.75
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.) **Fee:** $735.40 **Benefit:** 75% = $551.55
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) **Fee:** $101.50 **Benefit:** 75% = $76.15 85% = $86.30
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) **Fee:** $325.40 **Benefit:** 75% = $244.05 85% = $276.60
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) **Fee:** $423.00 **Benefit:** 75% = $317.25 85% = $361.50
42644	CORNEA OR SCLERA, removal of imbedded foreign body from (excluding aftercare) (Anaes.) **Fee:** $62.40 **Benefit:** 75% = $46.80 85% = $53.05
42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) **Fee:** $177.05 **Benefit:** 75% = $132.80 85% = $150.50

42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.) **Fee:** $62.40 **Benefit:** 75% = $46.80 85% = $53.05
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) **Fee:** $139.15 **Benefit:** 75% = $104.40 85% = $118.30
42653	CORNEA, transplantation of, full thickness (Anaes.) (Assist.) **Fee:** $1,158.40 **Benefit:** 75% = $868.80
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) **Fee:** $1,444.85 **Benefit:** 75% = $1,083.65
42659	CORNEA, transplantation of, superficial or lamellar (Anaes.) (Assist.) **Fee:** $780.95 **Benefit:** 75% = $585.75 85% = $719.45
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) **Fee:** $780.95 **Benefit:** 75% = $585.75
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.) **Fee:** $520.65 **Benefit:** 75% = $390.50 85% = $459.15
42667	RUNNING CORNEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism where a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) **Fee:** $65.20 **Benefit:** 75% = $48.90 85% = $55.45
42672	CORNEAL INCISONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $780.95 **Benefit:** 75% = $585.75 85% = $719.45
42673	ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.) **Fee:** $390.45 **Benefit:** 75% = $292.85 85% = $331.90
42676	CONJUNCTIVA, biopsy of, as an independent procedure **Fee:** $100.15 **Benefit:** 75% = $75.15 85% = $85.15
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) **Fee:** $52.75 **Benefit:** 75% = $39.60 85% = $44.85
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO^2 or N^20 (Anaes.) **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) **Fee:** $104.15 **Benefit:** 75% = $78.15
42686	PTERYGIUM, removal of (Anaes.) **Fee:** $236.90 **Benefit:** 75% = $177.70 85% = $201.40
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) **Fee:** $101.50 **Benefit:** 75% = $76.15 85% = $86.30
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) **Fee:** $239.50 **Benefit:** 75% = $179.65 85% = $203.60
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) **Fee:** $390.45 **Benefit:** 75% = $292.85 85% = $331.90
42698	LENS EXTRACTION, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.) **Fee:** $609.15 **Benefit:** 75% = $456.90

42701	ARTIFICIAL LENS, insertion of, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.) **Fee:** $339.65 **Benefit:** 75% = $254.75
42702	LENS EXTRACTION AND INSERTION OF ARTIFICIAL LENS, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.) **Fee:** $779.05 **Benefit:** 75% = $584.30
42703	ARTIFICIAL LENS, insertion of, into the posterior chamber and suture to the iris and sclera (Anaes.) (Assist.) **Fee:** $495.10 **Benefit:** 75% = $371.35
42704	ARTIFICIAL LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.) **Fee:** $403.40 **Benefit:** 75% = $302.55 85% = $342.90
I 42707	ARTIFICIAL LENS, REMOVAL of and REPLACEMENT with a different lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.) **Fee:** $689.85 **Benefit:** 75% = $517.40
42710	ARTIFICIAL LENS, removal of, and replacement with a lens inserted into the posterior chamber and sutured to the iris or sclera (Anaes.) (Assist.) **Fee:** $780.95 **Benefit:** 75% = $585.75
42713	INTRAOCULAR LENSES, repositioning of, by the use of a McCannell suture or similar (Anaes.) (Assist.) **Fee:** $325.40 **Benefit:** 75% = $244.05 85% = $276.60
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) **Fee:** $1,034.80 **Benefit:** 75% = $776.10
I 42719	CAPSULECTOMY OR REMOVAL OF VITREOUS, or both, via the anterior chamber by any method, not being a service associated with a service to which item 42698, 42702 or 42716 applies (Anaes.) (Assist.) **Fee:** $449.05 **Benefit:** 75% = $336.80 85% = $387.55
I 42722	CAPSULECTOMY by posterior chamber sclerotomy OR REMOVAL OF VITREOUS or VITREOUS BANDS, or both, from the anterior chamber by posterior chamber sclerotomy, by cutting and suction and infusion, not being a service associated with a service to which item 42698, 42702 or 42716 applies - 1 or both procedures (Anaes.) (Assist.) **Fee:** $491.30 **Benefit:** 75% = $368.50
I 42725	VITRECTOMY by posterior chamber sclerotomy including the removal of vitreous, division of bands or removal of preretinal membranes where performed, by cutting and suction and infusion (Anaes.) (Assist.) **Fee:** $1,158.40 **Benefit:** 75% = $868.80
42728	CRYOTHERAPY OF RETINA or other intraocular structures with an internal probe, being a service associated with a service to which item 42725 applies (Anaes.) **Fee:** $195.30 **Benefit:** 75% = $146.50
I 42731	CAPSULECTOMY or LENSECTOMY, or both, by posterior chamber sclerotomy in conjunction with the removal of vitreous or division of vitreous bands or removal of preretinal membrane from the posterior chamber by cutting and suction and infusion, not being a service associated with any other intraocular operation (Anaes.) (Assist.) *(See para T8.70 of explanatory notes to this Category)* **Fee:** $1,314.60 **Benefit:** 75% = $985.95
42734	CAPSULOTOMY, other than by laser (Anaes.) (Assist.) **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30
42737	NEEDLING OF POSTERIOR CAPSULE (Anaes.) (Assist.) **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30
42740	PARACENTESIS OF ANTERIOR OR POSTERIOR CHAMBER OR BOTH, for the injection of therapeutic substances, or the removal of aqueous or vitreous for diagnostic purposes, 1 or more of (Anaes.) (Assist.) **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) **Fee:** $546.75 **Benefit:** 75% = $410.10 85% = $485.25

H 42744	NEEDLING FOR DRAINAGE OF ENCYSTED BLEB, following trabeculectomy (Anaes.) **Fee:** $260.10 **Benefit:** 75% = $195.10 85% = $221.10
42746	GLAUCOMA, filtering operation for (Anaes.) (Assist.) **Fee:** $826.50 **Benefit:** 75% = $619.90
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) **Fee:** $1,034.80 **Benefit:** 75% = $776.10
42752	GLAUCOMA, insertion of Molteno valve for, 1 or more stages (Anaes.) (Assist.) **Fee:** $1,158.40 **Benefit:** 75% = $868.80
42755	GLAUCOMA, removal of Molteno valve (Anaes.) **Fee:** $143.20 **Benefit:** 75% = $107.40 85% = $121.75
42758	GONIOTOMY (Anaes.) (Assist.) **Fee:** $605.35 **Benefit:** 75% = $454.05
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $449.05 **Benefit:** 75% = $336.80 85% = $387.55
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $449.05 **Benefit:** 75% = $336.80 85% = $387.55
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) **Fee:** $943.65 **Benefit:** 75% = $707.75
42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $255.20 **Benefit:** 75% = $191.40 85% = $216.95
42771	CYCLODESTRUCTIVE PROCEDURES for the treatment of intractable glaucoma, treatment to one eye - ***where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which 42770 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $251.20 **Benefit:** 75% = $188.40 85% = $213.55
42773	DETACHED RETINA, diathermy or cryotherapy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) **Fee:** $780.95 **Benefit:** 75% = $585.75 85% = $719.45
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) **Fee:** $1,158.40 **Benefit:** 75% = $868.80
42779	DETACHED RETINA, revision operation for (Anaes.) (Assist.) **Fee:** $1,444.85 **Benefit:** 75% = $1,083.65
42782	LASER TRABECULOPLASTY - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $390.45 **Benefit:** 75% = $292.85 85% = $331.90
42783	LASER TRABECULOPLASTY - each treatment to 1 eye ***- where it can be demonstrated that a 5th or subsequent treatment to that eye (including any treatments to which item 42782 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $390.45 **Benefit:** 75% = $292.85 85% = $331.90
42785	LASER IRIDOTOMY - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.73 of explanatory notes to this Category)* **Fee:** $305.85 **Benefit:** 75% = $229.40 85% = $260.00
42786	LASER IRIDOTOMY - each treatment to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.73 of explanatory notes to this Category)* **Fee:** $305.85 **Benefit:** 75% = $229.40 85% = $260.00

42788	LASER CAPSULOTOMY - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.74 of explanatory notes to this Category)* **Fee:** $305.85	**Benefit:** 75% = $229.40	85% = $260.00
42789	LASER CAPSULOTOMY - each treatment to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.74 of explanatory notes to this Category)* **Fee:** $305.85	**Benefit:** 75% = $229.40	85% = $260.00
42791	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS -each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $305.85	**Benefit:** 75% = $229.40	85% = $260.00
42792	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS - each treatment to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $305.85	**Benefit:** 75% = $229.40	85% = $260.00
42794	DIVISION OF SUTURE BY LASER following trabeculoplasty, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) *(See para T8.76 of explanatory notes to this Category)* **Fee:** $58.55	**Benefit:** 75% = $43.95	85% = $49.80
42797	LASER COAGULATION OF CORNEAL OR SCLERAL BLOOD VESSELS - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) *(See para T8.77 of explanatory notes to this Category)* **Fee:** $58.55	**Benefit:** 75% = $43.95	85% = $49.80
H 42805	TANTALUM MARKERS, surgical insertion to the sclera to localise the tumour base to assist in planning of radiotherapy of choroidal melanomas, 1 or more (Anaes.) (Assist.) **Fee:** $507.55	**Benefit:** 75% = $380.70	85% = $446.05
42806	IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) **Fee:** $305.85	**Benefit:** 75% = $229.40	85% = $260.00
42807	PHOTOMYDRIASIS, laser **Fee:** $307.95	**Benefit:** 75% = $231.00	85% = $261.80
42808	PHOTOIRIDOSYNERESIS, laser **Fee:** $307.95	**Benefit:** 75% = $231.00	85% = $261.80
42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) **Fee:** $390.45	**Benefit:** 75% = $292.85	85% = $331.90
42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) **Fee:** $491.35	**Benefit:** 75% = $368.55	85% = $429.85
H 42811	TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) **Fee:** $390.45	**Benefit:** 75% = $292.85	85% = $331.90
42812	DETACHED RETINA, removal of encircling silicone band from (Anaes.) **Fee:** $143.20	**Benefit:** 75% = $107.40	85% = $121.75
42815	POSTERIOR CHAMBER, removal of silicone oil from (Anaes.) (Assist.) **Fee:** $546.75	**Benefit:** 75% = $410.10	
42818	RETINA, CRYOTHERAPY TO, as an independent procedure, with external probe (Anaes.) **Fee:** $507.55	**Benefit:** 75% = $380.70	85% = $446.05
I 42821	OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.) **Fee:** $78.15	**Benefit:** 75% = $58.65	85% = $66.45

42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure **Fee:** $60.50 **Benefit:** 75% = $45.40 85% = $51.45
42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES (Anaes.) (Assist.) **Fee:** $507.55 **Benefit:** 75% = $380.70
42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES where there have been 2 or more previous squint operations on the eye or eyes (Anaes.) (Assist.) **Fee:** $631.30 **Benefit:** 75% = $473.50
42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES (Anaes.) (Assist.) **Fee:** $605.35 **Benefit:** 75% = $454.05
42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES where there have been 2 or more previous squint operations on the eye or eyes (Anaes.) (Assist.) **Fee:** $754.95 **Benefit:** 75% = $566.25
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.) *(See para T8.78 of explanatory notes to this Category)* **Fee:** $163.90 **Benefit:** 75% = $122.95 85% = $139.35
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) (Anaes.) (Assist.) **Fee:** $605.35 **Benefit:** 75% = $454.05
42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) where there have been 2 or more previous squint operations on the eye or eyes (Anaes.) (Assist.) **Fee:** $754.95 **Benefit:** 75% = $566.25
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.) **Fee:** $780.95 **Benefit:** 75% = $585.75 85% = $719.45
42863	EYELID, recession of (Anaes.) (Assist.) **Fee:** $670.30 **Benefit:** 75% = $502.75 85% = $608.80
42866	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.) **Fee:** $650.75 **Benefit:** 75% = $488.10 85% = $589.25
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) **Fee:** $475.15 **Benefit:** 75% = $356.40 85% = $413.65
42872	EYEBROW, elevation of, for paretic states (Anaes.) **Fee:** $208.30 **Benefit:** 75% = $156.25 85% = $177.10
	SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS
	OPERATIONS FOR ACUTE OSTEOMYELITIS
43500	OPERATION ON PHALANX (Anaes.) **Fee:** $106.80 **Benefit:** 75% = $80.10
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.) **Fee:** $177.15 **Benefit:** 75% = $132.90
43506	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30

43509	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30
43512	**OPERATIONS FOR CHRONIC OSTEOMYELITIS** OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30
43515	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15
43518	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45
43521	OPERATION ON SKULL (Anaes.) (Assist.) **Fee:** $402.00 **Benefit:** 75% = $301.50
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45 85% = $447.05
	SUBGROUP 11 - PAEDIATRIC
43801	**SURGERY IN THE NEONATE OR YOUNG CHILD** INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) **Fee:** $828.50 **Benefit:** 75% = $621.40
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) **Fee:** $882.15 **Benefit:** 75% = $661.65
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.) **Fee:** $962.40 **Benefit:** 75% = $721.80
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) **Fee:** $1,122.85 **Benefit:** 75% = $842.15
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.) **Fee:** $1,122.85 **Benefit:** 75% = $842.15
43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.) **Fee:** $1,042.55 **Benefit:** 75% = $781.95
43819	HIRSCHSPRUNG'S DISEASE, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) **Fee:** $842.10 **Benefit:** 75% = $631.60
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.) **Fee:** $842.10 **Benefit:** 75% = $631.60
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $962.40 **Benefit:** 75% = $721.80
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,063.25 **Benefit:** 75% = $797.45
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) **Fee:** $828.50 **Benefit:** 75% = $621.40

43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $962.40 **Benefit:** 75% = $721.80
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) **Fee:** $1,202.95 **Benefit:** 75% = $902.25
43840	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.) (Assist.) **Fee:** $1,042.55 **Benefit:** 75% = $781.95
43843	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.) (Assist.) **Fee:** $1,603.95 **Benefit:** 75% = $1,203.00
43846	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.) (Assist.) **Fee:** $1,724.20 **Benefit:** 75% = $1,293.15
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) **Fee:** $441.10 **Benefit:** 75% = $330.85
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) **Fee:** $1,403.40 **Benefit:** 75% = $1,052.55 85% = $1,341.90
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) **Fee:** $1,483.70 **Benefit:** 75% = $1,112.80
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) **Fee:** $521.20 **Benefit:** 75% = $390.90 85% = $459.70
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) **Fee:** $1,443.60 **Benefit:** 75% = $1,082.70
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
43867	GASTROSCHISIS, secondary operation for, with removal of silo and closure of abdominal wall (Anaes.) (Assist.) **Fee:** $601.55 **Benefit:** 75% = $451.20
43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) **Fee:** $842.10 **Benefit:** 75% = $631.60
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) **Fee:** $1,122.85 **Benefit:** 75% = $842.15
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) **Fee:** $962.40 **Benefit:** 75% = $721.80
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) **Fee:** $1,122.85 **Benefit:** 75% = $842.15
43882	CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.) **Fee:** $1,443.60 **Benefit:** 75% = $1,082.70 85% = $1,382.10
	THORACIC SURGERY
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) **Fee:** $962.40 **Benefit:** 75% = $721.80
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) **Fee:** $1,603.95 **Benefit:** 75% = $1,203.00

43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) **Fee:** $1,403.40 **Benefit:** 75% = $1,052.55
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) **Fee:** $1,403.40 **Benefit:** 75% = $1,052.55
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) **Fee:** $1,325.90 **Benefit:** 75% = $994.45
43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) **Fee:** $1,002.50 **Benefit:** 75% = $751.90 85% = $941.00
	ABDOMINAL SURGERY
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) **Fee:** $385.50 **Benefit:** 75% = $289.15
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) **Fee:** $451.20 **Benefit:** 75% = $338.40
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) **Fee:** $842.10 **Benefit:** 75% = $631.60
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.) **Fee:** $641.65 **Benefit:** 75% = $481.25
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) **Fee:** $200.60 **Benefit:** 75% = $150.45 85% = $170.55
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) **Fee:** $842.10 **Benefit:** 75% = $631.60
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) **Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) **Fee:** $754.10 **Benefit:** 75% = $565.60
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) **Fee:** $922.40 **Benefit:** 75% = $691.80
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,002.50 **Benefit:** 75% = $751.90
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.) **Fee:** $352.70 **Benefit:** 75% = $264.55
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) **Fee:** $1,403.40 **Benefit:** 75% = $1,052.55
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) **Fee:** $1,603.95 **Benefit:** 75% = $1,203.00
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) **Fee:** $2,205.50 **Benefit:** 75% = $1,654.15
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) **Fee:** $1,603.95 **Benefit:** 75% = $1,203.00
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $1,884.70 **Benefit:** 75% = $1,413.55

43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) **Fee:** $1,603.95 **Benefit:** 75% = $1,203.00
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $441.10 **Benefit:** 75% = $330.85
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) **Fee:** $1,122.85 **Benefit:** 75% = $842.15
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) **Fee:** $1,243.15 **Benefit:** 75% = $932.40
43990	HIRSCHSPRUNG'S DISEASE, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.) **Fee:** $1,523.85 **Benefit:** 75% = $1,142.90
43993	HIRSCHSPRUNG'S DISEASE, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes.) (Assist.) **Fee:** $1,644.10 **Benefit:** 75% = $1,233.10 85% = $1,582.60
43996	HIRSCHPRUNG'S DISEASE, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) **Fee:** $1,844.60 **Benefit:** 75% = $1,383.45 85% = $1,783.10
43999	HIRSCHSPRUNG'S DISEASE, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) **Fee:** $230.65 **Benefit:** 75% = $173.00
44102	RECTUM, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $222.40 **Benefit:** 75% = $166.80
44105	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, under general anaesthesia (Anaes.) **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20
44108	INGUINAL HERNIA repair at age less than 3 months (Anaes.) (Assist.) **Fee:** $425.35 **Benefit:** 75% = $319.05
44111	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair of, at age less than 3 months, including orchidopexy when performed (Anaes.) (Assist.) **Fee:** $498.15 **Benefit:** 75% = $373.65 85% = $436.65
44114	INGUINAL HERNIA repair at age less than 3 months when orchidopexy also required (Anaes.) (Assist.) **Fee:** $498.15 **Benefit:** 75% = $373.65
	MISCELLANEOUS SURGERY
44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) **Fee:** $401.00 **Benefit:** 75% = $300.75 85% = $340.85
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) **Fee:** $318.25 **Benefit:** 75% = $238.70
44136	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
	SUBGROUP 12 - AMPUTATIONS
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.) **Fee:** $255.90 **Benefit:** 75% = $191.95 85% = $217.55
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30
44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45

44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) **Fee:** $1,033.60 **Benefit:** 75% = $775.20 85% = $972.10
44338	1 DIGIT of foot, amputation of (Anaes.) **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00
44342	2 DIGITS of 1 foot, amputation of (Anaes.) **Fee:** $190.35 **Benefit:** 75% = $142.80
44346	3 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $219.80 **Benefit:** 75% = $164.85
44350	4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $249.45 **Benefit:** 75% = $187.10 85% = $212.05
44354	5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $285.45 **Benefit:** 75% = $214.10
44358	TOE, including metatarsal or part of metatarsal each toe , amputation of (Anaes.) **Fee:** $159.15 **Benefit:** 75% = $119.40
44359	ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare (Anaes.) (Assist.) **Fee:** $228.40 **Benefit:** 75% = $171.30
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.) **Fee:** $255.90 **Benefit:** 75% = $191.95
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.) **Fee:** $451.65 **Benefit:** 75% = $338.75
44370	AMPUTATION AT HIP (Anaes.) (Assist.) **Fee:** $623.30 **Benefit:** 75% = $467.50
44373	HINDQUARTER, amputation of (Anaes.) (Assist.) **Fee:** $1,279.55 **Benefit:** 75% = $959.70 85% = $1,218.05
44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.) **Derived Fee:** 75% of the original amputation fee
	SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY
	METICULOUS REPAIR DESIGNED TO OBTAIN MAXIMUM FUNCTIONAL RESULTS INCLUDING THE PREPARATION OF THE DEFECT REQUIRING REPAIR *(Note: See Explanatory notes to this Category for definition of "Local skin flap")* **GENERAL**
45000	SINGLE STAGE LOCAL MUSCLE FLAP REPAIR, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes.) **Fee:** $468.55 **Benefit:** 75% = $351.45 85% = $407.05
45003	SINGLE STAGE LOCAL MYOCUTANEOUS FLAP REPAIR to 1 defect, simple and small (Anaes.) **Fee:** $520.65 **Benefit:** 75% = $390.50 85% = $459.15
45006	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.) **Fee:** $898.10 **Benefit:** 75% = $673.60
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.) **Fee:** $328.10 **Benefit:** 75% = $246.10

45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.) **Fee:** $549.55 **Benefit:** 75% = $412.20
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.) **Fee:** $260.30 **Benefit:** 75% = $195.25
45018	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) **Fee:** $409.95 **Benefit:** 75% = $307.50 85% = $348.50
45019	FULL FACE CHEMICAL PEEL **for severely sun-damaged skin,** ***where it can be demonstrated that the damage affects 75% of the facial skin surface area involving photodamage (dermatoheliosis) typically consisting of solar keratoses, solar lentigines, freckling, yellowing and leathering of the skin,*** where at least medium depth peeling agents are used, performed in the operating theatre of a hospital or approved day-hospital facility by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes.) *(See para T8.79 of explanatory notes to this Category)* **Fee:** $343.30 **Benefit:** 75% = $257.50
45020	FULL FACE CHEMICAL PEEL **for severe chloasma or melasma refractory to all other treatments**, ***where it can be demonstrated that the chloasma or melasma affects 75% of the facial skin surface area involving diffuse pigmentation visible at a distance of 4 metres***, *where at least medium depth peeling agents are used*, performed in the operating theatre of a hospital or approved day-hospital facility by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes.) *(See para T8.79 of explanatory notes to this Category)* **Fee:** $343.30 **Benefit:** 75% = $257.50 85% = $291.85
45021	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) *(See para T8.80 of explanatory notes to this Category)* **Fee:** $153.55 **Benefit:** 75% = $115.20 85% = $130.55
45024	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) *(See para T8.80 of explanatory notes to this Category)* **Fee:** $344.90 **Benefit:** 75% = $258.70 85% = $293.20
45025	CARBON DIOXIDE LASER OR ERBIUM LASER resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) *(See para T8.80 of explanatory notes to this Category)* **Fee:** $153.55 **Benefit:** 75% = $115.20 85% = $130.55
45026	CARBON DIOXIDE LASER OR ERBIUM LASER resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) *(See para T8.80 of explanatory notes to this Category)* **Fee:** $344.90 **Benefit:** 75% = $258.70 85% = $293.20
45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $104.15 **Benefit:** 75% = $78.15 85% = $88.55
45030	ANGIOMA (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.) **Fee:** $111.85 **Benefit:** 75% = $83.90 85% = $95.10
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) **Fee:** $208.30 **Benefit:** 75% = $156.25 85% = $177.10
45035	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.) **Fee:** $607.60 **Benefit:** 75% = $455.70
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.) **Fee:** $976.25 **Benefit:** 75% = $732.20
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.) **Fee:** $208.30 **Benefit:** 75% = $156.25 85% = $177.10

45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.) **Fee:** $266.90 **Benefit:** 75% = $200.20 85% = $226.90
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) **Fee:** $266.90 **Benefit:** 75% = $200.20 85% = $226.90
45048	LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.) **Fee:** $670.30 **Benefit:** 75% = $502.75
45051	CONTOUR RECONSTRUCTION for pathological deformity, insertion of foreign implant (non biological but excluding injection of liquid or semisolid material) by open operation (Anaes.) (Assist.) *(See para T8.81 of explanatory notes to this Category)* **Fee:** $410.05 **Benefit:** 75% = $307.55
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.) *(See para T8.82 of explanatory notes to this Category)* **Fee:** $212.95 **Benefit:** 75% = $159.75
	SKIN FLAP SURGERY *(Note: See Explanatory notes to this Category for definition of "Local skin flap")*
45200	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness (Anaes.) *(See para T8.83 of explanatory notes to this Category)* **Fee:** $246.10 **Benefit:** 75% = $184.60 85% = $209.20
45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals (Anaes.) **Fee:** $332.00 **Benefit:** 75% = $249.00 85% = $282.20
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.) **Fee:** $410.05 **Benefit:** 75% = $307.55 85% = $348.55
45212	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (Anaes.) **Fee:** $203.45 **Benefit:** 75% = $152.60 85% = $172.95
45215	DIRECT FLAP REPAIR, cross leg, first stage (Anaes.) (Assist.) **Fee:** $877.65 **Benefit:** 75% = $658.25
45218	DIRECT FLAP REPAIR, cross leg, second stage (Anaes.) (Assist.) **Fee:** $393.65 **Benefit:** 75% = $295.25
45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.) **Fee:** $226.30 **Benefit:** 75% = $169.75 85% = $192.40
45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.) **Fee:** $101.70 **Benefit:** 75% = $76.30 85% = $86.45
45227	INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.) **Fee:** $385.50 **Benefit:** 75% = $289.15 85% = $327.70
45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.) **Fee:** $192.70 **Benefit:** 75% = $144.55 85% = $163.80
45233	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.) **Fee:** $410.05 **Benefit:** 75% = $307.55 85% = $348.55
45236	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.) **Fee:** $321.55 **Benefit:** 75% = $241.20

45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of (Anaes.) **Fee:** $226.30 **Benefit:** 75% = $169.75 85% = $192.40
	FREE GRAFTS
45400	FREE GRAFTING (split skin) of a granulating area, small (Anaes.) **Fee:** $177.15 **Benefit:** 75% = $132.90 85% = $150.60
45403	FREE GRAFTING (split skin) of a granulating area, extensive (Anaes.) (Assist.) **Fee:** $352.70 **Benefit:** 75% = $264.55 85% = $299.80
45406	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes.) (Assist.) *(See para T8.84 of explanatory notes to this Category)* **Fee:** $390.45 **Benefit:** 75% = $292.85 85% = $331.90
45409	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 3 per cent or more but less than 6 per cent of total body surface (Anaes.) (Assist.) *(See para T8.84 of explanatory notes to this Category)* **Fee:** $520.65 **Benefit:** 75% = $390.50
45412	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (Anaes.) (Assist.) *(See para T8.84 of explanatory notes to this Category)* **Fee:** $715.95 **Benefit:** 75% = $537.00
45415	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (Anaes.) (Assist.) *(See para T8.84 of explanatory notes to this Category)* **Fee:** $780.95 **Benefit:** 75% = $585.75
45418	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more but less than 15 per cent of total body surface (Anaes.) (Assist.) *(See para T8.84 of explanatory notes to this Category)* **Fee:** $846.05 **Benefit:** 75% = $634.55
45439	FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (Anaes.) **Fee:** $246.10 **Benefit:** 75% = $184.60 85% = $209.20
45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.) **Fee:** $507.55 **Benefit:** 75% = $380.70 85% = $446.05
45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (Anaes.) (Assist.) **Fee:** $481.75 **Benefit:** 75% = $361.35 85% = $420.25
45448	FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.) **Fee:** $325.40 **Benefit:** 75% = $244.05 85% = $276.60
45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.) **Fee:** $410.05 **Benefit:** 75% = $307.55 85% = $348.55
45460	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **one surgeon** (Anaes.) (Assist.) **Fee:** $1,084.70 **Benefit:** 75% = $813.55
45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $773.05 **Benefit:** 75% = $579.80
45462	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, co- surgeon** (Assist.) **Fee:** $583.45 **Benefit:** 75% = $437.60

45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **one surgeon** (Anaes.) (Assist.) **Fee:** $1,655.75 **Benefit:** 75% = $1,241.85
45465	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $1,179.65 **Benefit:** 75% = $884.75 85% = $1,118.15
45466	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $889.60 **Benefit:** 75% = $667.20 85% = $828.10
45468	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $1,586.10 **Benefit:** 75% = $1,189.60
45469	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,196.65 **Benefit:** 75% = $897.50 85% = $1,135.15
45471	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $1,993.70 **Benefit:** 75% = $1,495.30 85% = $1,932.20
45472	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,503.80 **Benefit:** 75% = $1,127.85 85% = $1,442.30
45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $2,400.20 **Benefit:** 75% = $1,800.15 85% = $2,338.70
45475	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,810.95 **Benefit:** 75% = $1,358.25 85% = $1,749.45
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $2,806.75 **Benefit:** 75% = $2,105.10 85% = $2,745.25
45478	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,117.00 **Benefit:** 75% = $1,587.75 85% = $2,055.50
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $3,213.15 **Benefit:** 75% = $2,409.90 85% = $3,151.65
45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,424.25 **Benefit:** 75% = $1,818.20 85% = $2,362.75
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $3,660.85 **Benefit:** 75% = $2,745.65 85% = $3,599.35
45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,762.15 **Benefit:** 75% = $2,071.65 85% = $2,700.65
45485	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.) **Fee:** $456.70 **Benefit:** 75% = $342.55
45486	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.) **Fee:** $390.45 **Benefit:** 75% = $292.85

45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.) **Fee:** $390.45 **Benefit:** 75% = $292.85
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.) **Fee:** $585.80 **Benefit:** 75% = $439.35 85% = $524.30
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.) **Fee:** $781.05 **Benefit:** 75% = $585.80
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.) **Fee:** $976.25 **Benefit:** 75% = $732.20
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.) **Fee:** $1,171.50 **Benefit:** 75% = $878.65
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55
45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.) **Fee:** $1,418.20 **Benefit:** 75% = $1,063.65 85% = $1,356.70
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
45496	FLAP, free tissue transfer using microvascular techniques - ***revision of***, by open operation (Anaes.) **Fee:** $360.05 **Benefit:** 75% = $270.05
45497	FLAP, free tissue transfer using microvascular techniques - ***complete revision of***, by liposuction (Anaes.) **Fee:** $281.25 **Benefit:** 75% = $210.95
45498	FLAP, free tissue transfer using microvascular techniques - ***staged revision of***, by liposuction - first stage (Anaes.) **Fee:** $226.30 **Benefit:** 75% = $169.75
45499	FLAP, free tissue transfer using microvascular techniques - ***staged revision of***, by liposuction - second stage (Anaes.) **Fee:** $168.75 **Benefit:** 75% = $126.60
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) **Fee:** $943.65 **Benefit:** 75% = $707.75
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,535.95 **Benefit:** 75% = $1,152.00
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,535.95 **Benefit:** 75% = $1,152.00
45503	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,757.25 **Benefit:** 75% = $1,317.95
45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,535.95 **Benefit:** 75% = $1,152.00
45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,535.95 **Benefit:** 75% = $1,152.00
45506	SCAR, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes.) *(See para T8.85 of explanatory notes to this Category)* **Fee:** $190.35 **Benefit:** 75% = $142.80 85% = $161.80

45512	SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes.) *(See para T8.85 of explanatory notes to this Category)* **Fee:** $255.90 **Benefit:** 75% = $191.95 85% = $217.55
45515	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes.) *(See para T8.85 of explanatory notes to this Category)* **Fee:** $161.40 **Benefit:** 75% = $121.05 85% = $137.20
45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her speciality (Anaes.) *(See para T8.85 of explanatory notes to this Category)* **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.) **Fee:** $371.35 **Benefit:** 75% = $278.55
45520	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple (Anaes.) (Assist.) **Fee:** $779.30 **Benefit:** 75% = $584.50
45522	REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple (Anaes.) (Assist.) **Fee:** $546.75 **Benefit:** 75% = $410.10 85% = $485.25
45524	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast (Anaes.) (Assist.) *(See para T8.86 of explanatory notes to this Category)* **Fee:** $641.90 **Benefit:** 75% = $481.45
45527	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (Anaes.) (Assist.) *(See para T8.86 of explanatory notes to this Category)* **Fee:** $641.90 **Benefit:** 75% = $481.45
45528	MAMMAPLASTY, AUGMENTATION, bilateral, not being a service to which Item 45527 applies, ***where it can be demonstrated*** that surgery is indicated because of malformation of breast tissue (excluding hypomastia), disease or trauma of the breast (other than trauma resulting from previous elective cosmetic surgery) (Anaes.) (Assist.) *(See para T8.86 of explanatory notes to this Category)* **Fee:** $962.75 **Benefit:** 75% = $722.10
45530	BREAST RECONSTRUCTION (unilateral) using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, being a service associated with item 30178 (Anaes.) (Assist.) *(See para T8.87 of explanatory notes to this Category)* **Fee:** $951.50 **Benefit:** 75% = $713.65
I 45533	BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes.) (Assist.) **Fee:** $1,077.60 **Benefit:** 75% = $808.20
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.) **Fee:** $396.25 **Benefit:** 75% = $297.20
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $927.15 **Benefit:** 75% = $695.40
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.) **Fee:** $530.85 **Benefit:** 75% = $398.15
45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.) *(See para T8.89 of explanatory notes to this Category)* **Fee:** $538.75 **Benefit:** 75% = $404.10 85% = $477.25

45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple *(See para T8.89 of explanatory notes to this Category)* **Fee:** $171.25 **Benefit:** 75% = $128.45 85% = $145.60
45548	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.) **Fee:** $239.50 **Benefit:** 75% = $179.65 85% = $203.60
45551	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.) **Fee:** $384.00 **Benefit:** 75% = $288.00
45552	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule and replacement of prosthesis (Anaes.) (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60 85% = $491.30
45554	BREAST PROSTHESIS, replacement of, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule (Anaes.) (Assist.) **Fee:** $605.35 **Benefit:** 75% = $454.05 85% = $543.85
45555	SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes.) (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60
45556	BREAST PTOSIS, correction of (unilateral), to match the position of the contralateral breast (Anaes.) (Assist.) *(See para T8.88 of explanatory notes to this Category)* **Fee:** $662.95 **Benefit:** 75% = $497.25 85% = $601.45
45557	BREAST PTOSIS, correction of by mastopexy of (unilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and ***where it can be demonstrated*** that the nipple is inferior to the infra-mammary groove (Anaes.) (Assist.) *(See para T8.88 of explanatory notes to this Category)* **Fee:** $662.95 **Benefit:** 75% = $497.25
45558	BREAST PTOSIS, correction of by mastopexy of (bilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and ***where it can be demonstrated*** that the nipple is inferior to the infra-mammary groove (Anaes.) (Assist.) *(See para T8.88 of explanatory notes to this Category)* **Fee:** $994.40 **Benefit:** 75% = $745.80
45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.) **Fee:** $409.95 **Benefit:** 75% = $307.50 85% = $348.50
45562	FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $951.50 **Benefit:** 75% = $713.65 85% = $890.00
45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $951.50 **Benefit:** 75% = $713.65 85% = $890.00
45564	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, principal specialist surgeon (Anaes.) (Assist.) **Fee:** $2,203.70 **Benefit:** 75% = $1,652.80
45565	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, conjoint specialist surgeon (Assist.) **Fee:** $1,652.85 **Benefit:** 75% = $1,239.65
45566	TISSUE EXPANSION not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $927.15 **Benefit:** 75% = $695.40

45568	TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.) **Fee:** $384.00 **Benefit:** 75% = $288.00
45572	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.) **Fee:** $252.50 **Benefit:** 75% = $189.40 85% = $214.65
45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) **Fee:** $623.30 **Benefit:** 75% = $467.50 85% = $561.80
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) **Fee:** $721.90 **Benefit:** 75% = $541.45
45581	FACIAL NERVE PALSY, excision of tissue for (Anaes.) **Fee:** $239.50 **Benefit:** 75% = $179.65 85% = $203.60
45584	LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.) *(See para T8.90 of explanatory notes to this Category)* **Fee:** $546.75 **Benefit:** 75% = $410.10 85% = $485.25
45585	LIPOSUCTION (suction assisted lipolysis) to 1 regional area, not being a service associated with a service to which item 31521 or 31527 applies, ***where it can be demonstrated*** that the treatment is for pathological lipodystrophy of hips, buttocks, thighs, knees or lower legs (Barraquer-Simon's Syndrome), gynaecomastia, or lymphoedema (Anaes.) *(See para T8.90 of explanatory notes to this Category)* **Fee:** $546.75 **Benefit:** 75% = $410.10 85% = $485.25
45586	LIPOSUCTION (suction assisted lipolysis) for reduction of a buffalo hump, ***where it can be demonstrated that the buffalo hump is secondary to an endocrine disorder or pharmacological treatment of a medical condition*** (Anaes.) *(See para T8.90 of explanatory notes to this Category)* **Fee:** $546.75 **Benefit:** 75% = $410.10
45587	MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Anaes.) (Assist.) *(See para T8.91 of explanatory notes to this Category)* **Fee:** $771.00 **Benefit:** 75% = $578.25 85% = $709.50
45588	MELOPLASTY, (excluding browlifts and chinlift platysmaplasties), bilateral ***where it can be demonstrated*** that surgery is indicated because of congenital conditions, disease or trauma (other than trauma resulting from previous elective cosmetic surgery) (Anaes.) (Assist.) *(See para T8.91 of explanatory notes to this Category)* **Fee:** $1,156.60 **Benefit:** 75% = $867.45
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.) **Fee:** $418.25 **Benefit:** 75% = $313.70
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) **Fee:** $491.30 **Benefit:** 75% = $368.50
45596	MAXILLA, total resection of (Anaes.) (Assist.) **Fee:** $779.30 **Benefit:** 75% = $584.50
45597	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) **Fee:** $1,043.20 **Benefit:** 75% = $782.40
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) **Fee:** $810.60 **Benefit:** 75% = $607.95 85% = $749.10
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $605.35 **Benefit:** 75% = $454.05
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45

45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.) **Fee:** $715.95 **Benefit:** 75% = $537.00
45611	MANDIBLE, condylectomy (Anaes.) (Assist.) **Fee:** $410.05 **Benefit:** 75% = $307.55
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.) **Fee:** $508.55 **Benefit:** 75% = $381.45 85% = $447.05
45617	UPPER EYELID, REDUCTION OF, for skin redundancy obscuring vision (as evidenced by upper eyelid skin resting on lashes on straight ahead gaze), herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of 1 of these conditions (Anaes.) *(See para T8.92 of explanatory notes to this Category)* **Fee:** $203.45 **Benefit:** 75% = $152.60 85% = $172.95
45620	LOWER EYELID, REDUCTION OF, for herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or, in respect of 1 of these conditions, the restoration of symmetry of the contralateral lower eyelid (Anaes.) *(See para T8.92 of explanatory notes to this Category)* **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85
45623	PTOSIS of eyelid (unilateral), correction of (Anaes.) (Assist.) **Fee:** $625.80 **Benefit:** 75% = $469.35 85% = $564.30
45624	PTOSIS of eyelid, correction of, where previous ptosis surgery has been performed on that side (Anaes.) (Assist.) **Fee:** $811.30 **Benefit:** 75% = $608.50 85% = $749.80
45625	PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $162.30 **Benefit:** 75% = $121.75
45626	ECTROPION OR ENTROPION, correction of (unilateral) (Anaes.) **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85
45629	SYMBLEPHARON, grafting for (Anaes.) (Assist.) **Fee:** $410.05 **Benefit:** 75% = $307.55 85% = $348.55
45632	RHINOPLASTY, correction of lateral or alar cartilages (Anaes.) **Fee:** $443.05 **Benefit:** 75% = $332.30 85% = $381.55
45635	RHINOPLASTY, correction of bony vault only (Anaes.) **Fee:** $508.55 **Benefit:** 75% = $381.45 85% = $447.05
45638	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, for correction of nasal obstruction or post-traumatic deformity ***(but not as a result of previous elective cosmetic surgery),*** or both (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $877.65 **Benefit:** 75% = $658.25 85% = $816.15
45639	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, ***where it can be demonstrated*** that there is a need for correction of significant developmental deformity (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $877.65 **Benefit:** 75% = $658.25 85% = $816.15
45641	RHINOPLASTY involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (Anaes.) **Fee:** $937.20 **Benefit:** 75% = $702.90 85% = $875.70
45644	RHINOPLASTY involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,107.35 **Benefit:** 75% = $830.55 85% = $1,045.85
45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.) **Fee:** $193.55 **Benefit:** 75% = $145.20
45646	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.) **Fee:** $779.30 **Benefit:** 75% = $584.50 85% = $717.80

45647	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.) *(See para T8.94 of explanatory notes to this Category)* **Fee:** $1,107.35 **Benefit:** 75% = $830.55
45650	RHINOPLASTY, secondary revision of (Anaes.) **Fee:** $127.95 **Benefit:** 75% = $96.00 85% = $108.80
45652	RHINOPHYMA, carbon dioxide laser or erbium laser excision-ablation of (Anaes.) **Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15
45653	RHINOPHYMA, shaving of (Anaes.) **Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $434.70 **Benefit:** 75% = $326.05 85% = $373.20
45659	LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (Anaes.) **Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $389.60
45660	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) **Fee:** $2,491.50 **Benefit:** 75% = $1,868.65
45661	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) **Fee:** $1,107.35 **Benefit:** 75% = $830.55
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.) **Fee:** $606.90 **Benefit:** 75% = $455.20
45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.) **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85
45668	VERMILIONECTOMY, by surgical excision (Anaes.) **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85
45669	VERMILIONECTOMY, using carbon dioxide laser or erbium laser excision-ablation (Anaes.) *(See para T8.95 of explanatory notes to this Category)* **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $721.90 **Benefit:** 75% = $541.45 85% = $660.40
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $209.95 **Benefit:** 75% = $157.50 85% = $178.50
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $418.25 **Benefit:** 75% = $313.70
45676	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $497.90 **Benefit:** 75% = $373.45
45677	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $468.55 **Benefit:** 75% = $351.45
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $585.80 **Benefit:** 75% = $439.35
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $650.75 **Benefit:** 75% = $488.10
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $768.05 **Benefit:** 75% = $576.05

45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $226.50 **Benefit:** 75% = $169.90
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $423.00 **Benefit:** 75% = $317.25
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.) **Fee:** $397.00 **Benefit:** 75% = $297.75
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $715.95 **Benefit:** 75% = $537.00
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $676.75 **Benefit:** 75% = $507.60
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) **Fee:** $423.00 **Benefit:** 75% = $317.25
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $481.75 **Benefit:** 75% = $361.35
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.) **Fee:** $676.75 **Benefit:** 75% = $507.60
45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $676.75 **Benefit:** 75% = $507.60
45720	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $836.70 **Benefit:** 75% = $627.55 85% = $775.20
45723	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $943.65 **Benefit:** 75% = $707.75
45726	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,066.30 **Benefit:** 75% = $799.75
45729	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,197.50 **Benefit:** 75% = $898.15
45731	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,214.00 **Benefit:** 75% = $910.50
45732	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,366.75 **Benefit:** 75% = $1,025.10

45735	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,394.30 **Benefit:** 75% = $1,045.75
45738	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,568.55 **Benefit:** 75% = $1,176.45
45741	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,533.90 **Benefit:** 75% = $1,150.45
45744	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,724.60 **Benefit:** 75% = $1,293.45
45747	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,673.40 **Benefit:** 75% = $1,255.05 85% = $1,611.90
45752	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $1,874.40 **Benefit:** 75% = $1,405.80
45753	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) **Fee:** $1,885.55 **Benefit:** 75% = $1,414.20 85% = $1,824.05
45754	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) **Fee:** $2,260.25 **Benefit:** 75% = $1,695.20
45755	TEMPOROMANDIBULAR MENISCECTOMY (Anaes.) (Assist.) **Fee:** $318.25 **Benefit:** 75% = $238.70 85% = $270.55
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.) **Fee:** $569.55 **Benefit:** 75% = $427.20
45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $647.95 **Benefit:** 75% = $486.00
45767	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.) **Fee:** $2,173.70 **Benefit:** 75% = $1,630.30 85% = $2,112.20
45770	HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.) **Fee:** $1,665.10 **Benefit:** 75% = $1,248.85
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.) **Fee:** $1,517.50 **Benefit:** 75% = $1,138.15 85% = $1,456.00
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) **Fee:** $1,517.50 **Benefit:** 75% = $1,138.15

45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) **Fee:** $1,115.65 **Benefit:** 75% = $836.75
45782	FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.) **Fee:** $853.15 **Benefit:** 75% = $639.90 85% = $791.65
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.) **Fee:** $1,443.65 **Benefit:** 75% = $1,082.75
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes.) (Assist.) **Fee:** $1,427.25 **Benefit:** 75% = $1,070.45
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $771.00 **Benefit:** 75% = $578.25
45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture (Anaes.) **Fee:** $436.10 **Benefit:** 75% = $327.10
45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment (Anaes.) **Fee:** $161.40 **Benefit:** 75% = $121.05
	ORAL AND MAXILLOFACIAL SURGERY
45799	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) **Fee:** $25.50 **Benefit:** 75% = $19.15 85% = $21.70
45801	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation),in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 45803 applies (Anaes.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $109.85 **Benefit:** 75% = $82.40 85% = $93.40
45803	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85
45805	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $149.30 **Benefit:** 75% = $112.00 85% = $126.95
45807	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in this Subgroup applies, involving muscle, bone, or other deep tissue (Anaes.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $213.30 **Benefit:** 75% = $160.00 85% = $181.35
45809	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35

45811	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $434.70	**Benefit:** 75% = $326.05	85% = $373.20
45813	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $508.55	**Benefit:** 75% = $381.45	85% = $447.05
45815	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $308.40	**Benefit:** 75% = $231.30	85% = $262.15
45817	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) **Fee:** $402.00	**Benefit:** 75% = $301.50	85% = $341.70
45819	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.) **Fee:** $508.50	**Benefit:** 75% = $381.40	85% = $447.00
45821	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.) **Fee:** $329.55	**Benefit:** 75% = $247.20	85% = $280.15
45823	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $94.25	**Benefit:** 75% = $70.70	85% = $80.15
45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $292.80	**Benefit:** 75% = $219.60	85% = $248.90
45827	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $279.90	**Benefit:** 75% = $209.95	85% = $237.95
45829	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $213.50	**Benefit:** 75% = $160.15	85% = $181.50
45831	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) **Fee:** $279.90	**Benefit:** 75% = $209.95	85% = $237.95
45833	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) **Fee:** $351.40	**Benefit:** 75% = $263.55	85% = $298.70
45835	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) **Fee:** $436.10	**Benefit:** 75% = $327.10	85% = $374.60
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $507.55	**Benefit:** 75% = $380.70	85% = $446.05
45839	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) **Fee:** $507.55	**Benefit:** 75% = $380.70	85% = $446.05
45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $409.95	**Benefit:** 75% = $307.50	85% = $348.50
45843	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) **Fee:** $251.40	**Benefit:** 75% = $188.55	85% = $213.70
45845	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $436.10	**Benefit:** 75% = $327.10	85% = $374.60

45847	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $161.40	**Benefit:** 75% = $121.05	85% = $137.20
45849	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) **Fee:** $502.70	**Benefit:** 75% = $377.05	85% = $441.20
45851	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) **Fee:** $123.70	**Benefit:** 75% = $92.80	85% = $105.15
45853	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $771.00	**Benefit:** 75% = $578.25	85% = $709.50
45855	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) **Fee:** $353.70	**Benefit:** 75% = $265.30	85% = $300.65
45857	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes.) (Assist.) **Fee:** $565.80	**Benefit:** 75% = $424.35	85% = $504.30
45859	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $285.25	**Benefit:** 75% = $213.95	85% = $242.50
45861	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $754.95	**Benefit:** 75% = $566.25	85% = $693.45
45863	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $836.90	**Benefit:** 75% = $627.70	85% = $775.40
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $251.40	**Benefit:** 75% = $188.55	85% = $213.70
45867	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $270.30	**Benefit:** 75% = $202.75	85% = $229.80
45869	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,028.35	**Benefit:** 75% = $771.30	85% = $966.85
45871	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,158.40	**Benefit:** 75% = $868.80	85% = $1,096.90
45873	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,301.65	**Benefit:** 75% = $976.25	85% = $1,240.15
45875	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $407.35	**Benefit:** 75% = $305.55	85% = $346.25
45877	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $407.35	**Benefit:** 75% = $305.55	85% = $346.25
45879	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $270.30	**Benefit:** 75% = $202.75	85% = $229.80

	SUBGROUP 14 - HAND SURGERY
	Note: Items 46300 to 46534 are restricted to surgery on the hand/s.
46300	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of (Anaes.) (Assist.) **Fee:** $292.85 **Benefit:** 75% = $219.65
46303	CARPOMETACARPAL JOINT, arthrodesis of (Anaes.) (Assist.) **Fee:** $325.50 **Benefit:** 75% = $244.15
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $455.65 **Benefit:** 75% = $341.75
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $455.65 **Benefit:** 75% = $341.75
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.) **Fee:** $455.65 **Benefit:** 75% = $341.75
46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.) **Fee:** $585.90 **Benefit:** 75% = $439.45
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.) (Assist.) **Fee:** $781.10 **Benefit:** 75% = $585.85
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.) (Assist.) **Fee:** $976.45 **Benefit:** 75% = $732.35
46321	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Anaes.) (Assist.) **Fee:** $1,171.80 **Benefit:** 75% = $878.85 85% = $1,110.30
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $698.75 **Benefit:** 75% = $524.10
46325	CARPAL BONE REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $729.15 **Benefit:** 75% = $546.90
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.) **Fee:** $175.85 **Benefit:** 75% = $131.90 85% = $149.50
46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of, with ligamentous or capsular repair (Anaes.) (Assist.) **Fee:** $299.50 **Benefit:** 75% = $224.65
46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.) **Fee:** $488.20 **Benefit:** 75% = $366.15
46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (Anaes.) (Assist.) **Fee:** $227.90 **Benefit:** 75% = $170.95 85% = $193.75
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.) **Fee:** $403.50 **Benefit:** 75% = $302.65 85% = $343.00
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes.) (Assist.) **Fee:** $403.50 **Benefit:** 75% = $302.65

46345	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.) **Fee:** $488.20 **Benefit:** 75% = $366.15
46348	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes.) **Fee:** $211.55 **Benefit:** 75% = $158.70 85% = $179.85
46351	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.) **Fee:** $315.70 **Benefit:** 75% = $236.80
46354	DIGIT, synovectomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.) **Fee:** $423.10 **Benefit:** 75% = $317.35
46357	DIGIT, synovectomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.) **Fee:** $527.30 **Benefit:** 75% = $395.50 85% = $465.80
46360	DIGIT, synovectomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.) **Fee:** $634.65 **Benefit:** 75% = $476.00
46363	TENDON SHEATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS (Anaes.) **Fee:** $182.25 **Benefit:** 75% = $136.70 85% = $154.95
46366	DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.) **Fee:** $110.70 **Benefit:** 75% = $83.05 85% = $94.10
46369	DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.) **Fee:** $182.25 **Benefit:** 75% = $136.70 85% = $154.95
46372	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $370.30 **Benefit:** 75% = $277.75 85% = $314.80
46375	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $439.40 **Benefit:** 75% = $329.55 85% = $377.90
46378	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $585.90 **Benefit:** 75% = $439.45
46381	INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture - each procedure (Anaes.) (Assist.) **Fee:** $260.35 **Benefit:** 75% = $195.30
46384	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (Anaes.) (Assist.) **Fee:** $260.35 **Benefit:** 75% = $195.30
46387	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes.) (Assist.) **Fee:** $537.10 **Benefit:** 75% = $402.85 85% = $475.60
46390	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $716.10 **Benefit:** 75% = $537.10
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $829.95 **Benefit:** 75% = $622.50
46396	PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50
46399	PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $448.20 **Benefit:** 75% = $336.15
46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.) (Assist.) **Fee:** $448.20 **Benefit:** 75% = $336.15

46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.) (Assist.) **Fee:** $546.85 **Benefit:** 75% = $410.15
46408	TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.) **Fee:** $598.95 **Benefit:** 75% = $449.25
46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.) **Fee:** $351.50 **Benefit:** 75% = $263.65
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.) (Assist.) **Fee:** $455.55 **Benefit:** 75% = $341.70 85% = $394.05
46417	TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.) **Fee:** $423.10 **Benefit:** 75% = $317.35
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.) **Fee:** $177.05 **Benefit:** 75% = $132.80 85% = $150.50
46423	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.) **Fee:** $283.15 **Benefit:** 75% = $212.40 85% = $240.70
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $292.85 **Benefit:** 75% = $219.65
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $358.00 **Benefit:** 75% = $268.50 85% = $304.30
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $390.65 **Benefit:** 75% = $293.00
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $455.65 **Benefit:** 75% = $341.75
46438	MALLET FINGER, closed pin fixation of (Anaes.) **Fee:** $117.20 **Benefit:** 75% = $87.90 85% = $99.65
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.) **Fee:** $283.15 **Benefit:** 75% = $212.40 85% = $240.70
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) **Fee:** $243.05 **Benefit:** 75% = $182.30
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $423.10 **Benefit:** 75% = $317.35
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $527.30 **Benefit:** 75% = $395.50
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) **Fee:** $195.30 **Benefit:** 75% = $146.50
46453	FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.) **Fee:** $325.50 **Benefit:** 75% = $244.15
46456	FINGER, percutaneous tenotomy of (Anaes.) **Fee:** $84.60 **Benefit:** 75% = $63.45 85% = $71.95
46459	OPERATION for OSTEOMYELITIS on distal phalanx (Anaes.) **Fee:** $162.80 **Benefit:** 75% = $122.10 85% = $138.40
46462	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.) **Fee:** $260.35 **Benefit:** 75% = $195.30 85% = $221.30
46464	AMPUTATION of a supernumerary complete digit (Anaes.) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05

46465	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
46468	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $341.75 **Benefit:** 75% = $256.35
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $488.20 **Benefit:** 75% = $366.15 85% = $426.70
46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $634.65 **Benefit:** 75% = $476.00
46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $781.10 **Benefit:** 75% = $585.85
46480	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.) **Fee:** $260.35 **Benefit:** 75% = $195.30 85% = $221.30
46486	NAIL BED, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
46489	NAIL BED, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (Assist.) **Fee:** $227.90 **Benefit:** 75% = $170.95 85% = $193.75
46492	CONTRACTURE OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes.) (Assist.) **Fee:** $312.50 **Benefit:** 75% = $234.40
46494	GANGLION OF HAND, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $190.35 **Benefit:** 75% = $142.80 85% = $161.80
46495	GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) **Fee:** $175.85 **Benefit:** 75% = $131.90 85% = $149.50
46498	GANGLION OF FLEXOR TENDON SHEATH, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) **Fee:** $190.35 **Benefit:** 75% = $142.80 85% = $161.80
46500	GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $227.90 **Benefit:** 75% = $170.95 85% = $193.75
46501	GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $284.85 **Benefit:** 75% = $213.65 85% = $242.15
46502	RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $262.15 **Benefit:** 75% = $196.65 85% = $222.85
46503	RECURRENT GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $327.45 **Benefit:** 75% = $245.60 85% = $278.35

46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.) **Fee:** $956.85 **Benefit:** 75% = $717.65 85% = $895.35
46507	DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.) **Fee:** $1,113.10 **Benefit:** 75% = $834.85
46510	MACRODACTYLY, surgical reduction of enlarged elements - each digit (Anaes.) (Assist.) **Fee:** $303.80 **Benefit:** 75% = $227.85
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies (Anaes.) **Fee:** $48.90 **Benefit:** 75% = $36.70 85% = $41.60
46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
46519	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.) **Fee:** $122.25 **Benefit:** 75% = $91.70 85% = $103.95
46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB, open operation and drainage for infection (Anaes.) (Assist.) **Fee:** $364.55 **Benefit:** 75% = $273.45
46525	PULP SPACE INFECTION, PARONYCHIA OF HAND, incision for, when performed in an operating theatre of a hospital or approved day-hospital facility, not being a service to which another item in this Group applies (excluding after-care) (Anaes.) **Fee:** $48.90 **Benefit:** 75% = $36.70 85% = $41.60
46528	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) **Fee:** $73.70 **Benefit:** 75% = $55.30 85% = $62.65
46534	NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
	SUBGROUP 15 - ORTHOPAEDIC
47000	**TREATMENT OF DISLOCATIONS** *(Note: See paragraph T8.92 of explanatory notes to this Category)* MANDIBLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
47003	CLAVICLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $73.35 **Benefit:** 75% = $55.05 85% = $62.35
47006	CLAVICLE, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $147.35 **Benefit:** 75% = $110.55 85% = $125.25
47009	SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.) (Assist.) **Fee:** $293.30 **Benefit:** 75% = $220.00
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia **Fee:** $73.35 **Benefit:** 75% = $55.05 85% = $62.35
47018	ELBOW, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $171.00 **Benefit:** 75% = $128.25 85% = $145.35
47021	ELBOW, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $228.15 **Benefit:** 75% = $171.15

47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) **Fee:** $171.00 **Benefit:** 75% = $128.25 85% = $145.35
47027	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) (Assist.) **Fee:** $228.15 **Benefit:** 75% = $171.15
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $171.00 **Benefit:** 75% = $128.25 85% = $145.35
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $228.15 **Benefit:** 75% = $171.15 85% = $193.95
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $73.35 **Benefit:** 75% = $55.05 85% = $62.35
47039	INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47045	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $130.45 **Benefit:** 75% = $97.85 85% = $110.90
47048	HIP, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $281.10 **Benefit:** 75% = $210.85 85% = $238.95
47051	HIP, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10
47054	KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.) **Fee:** $281.10 **Benefit:** 75% = $210.85 85% = $238.95
47057	PATELLA, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $109.95 **Benefit:** 75% = $82.50 85% = $93.50
47060	PATELLA, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47063	ANKLE or TARSUS, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $220.00 **Benefit:** 75% = $165.00 85% = $187.00
47066	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $293.30 **Benefit:** 75% = $220.00
47069	TOE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
47072	TOE, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $81.35 **Benefit:** 75% = $61.05 85% = $69.15
	TREATMENT OF FRACTURES *(Note: See paragraph T8.92 of explanatory notes to this Category)*
47300	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by closed reduction, including percutaneous fixation where used (Anaes.) **Fee:** $73.35 **Benefit:** 75% = $55.05 85% = $62.35
47303	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $85.60 **Benefit:** 75% = $64.20 85% = $72.80

47306	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by open reduction (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47309	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by open reduction (Anaes.) **Fee:** $122.25 **Benefit:** 75% = $91.70 85% = $103.95
47312	MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $109.95 **Benefit:** 75% = $82.50 85% = $93.50
47315	MIDDLE PHALANX of FINGER, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $126.30 **Benefit:** 75% = $94.75 85% = $107.40
47318	MIDDLE PHALANX OF FINGER, treatment of fracture of, by open reduction (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47321	MIDDLE PHALANX OF FINGER, treatment of intra-articular fracture of, by open reduction (Anaes.) **Fee:** $183.30 **Benefit:** 75% = $137.50
47324	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47327	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $171.00 **Benefit:** 75% = $128.25 85% = $145.35
47330	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by open reduction (Anaes.) **Fee:** $195.60 **Benefit:** 75% = $146.70 85% = $166.30
47333	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (Anaes.) (Assist.) **Fee:** $244.35 **Benefit:** 75% = $183.30
47336	METACARPAL, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47339	METACARPAL, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $171.00 **Benefit:** 75% = $128.25 85% = $145.35
47342	METACARPAL, treatment of fracture of, by open reduction (Anaes.) **Fee:** $195.60 **Benefit:** 75% = $146.70 85% = $166.30
47345	METACARPAL, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $244.35 **Benefit:** 75% = $183.30
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.) **Fee:** $81.35 **Benefit:** 75% = $61.05 85% = $69.15
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50 85% = $277.10
47360	RADIUS OR ULNA, distal end of, treatment of fracture of, by cast immobilisation, not being a service to which item 47363 or 47366 applies (Anaes.) **Fee:** $114.10 **Benefit:** 75% = $85.60 85% = $97.00
47363	RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $171.00 **Benefit:** 75% = $128.25 85% = $145.35
47366	RADIUS OR ULNA, distal end of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $228.15 **Benefit:** 75% = $171.15 85% = $193.95
47369	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, not being a service to which item 47372 or 47375 applies (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70

47372	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) **Fee:** $244.35 **Benefit:** 75% = $183.30 85% = $207.70
47375	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50
47378	RADIUS OR ULNA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47381	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $220.00 **Benefit:** 75% = $165.00 85% = $187.00
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $293.30 **Benefit:** 75% = $220.00
47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (Assist.) **Fee:** $252.55 **Benefit:** 75% = $189.45 85% = $214.70
47386	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Anaes.) (Assist.) **Fee:** $407.35 **Benefit:** 75% = $305.55
47387	RADIUS AND ULNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20 85% = $200.85
47390	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $354.45 **Benefit:** 75% = $265.85
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $472.55 **Benefit:** 75% = $354.45
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes.) **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) **Fee:** $244.35 **Benefit:** 75% = $183.30 85% = $207.70
47405	RADIUS, treatment of fracture of head or neck of, closed management of (Anaes.) **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55
47408	RADIUS, treatment of fracture of head or neck of, open management of, including internal fixation and excision where performed (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.) **Fee:** $195.60 **Benefit:** 75% = $146.70 85% = $166.30
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $228.15 **Benefit:** 75% = $171.15 85% = $193.95
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $448.20 **Benefit:** 75% = $336.15
47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.) **Fee:** $187.35 **Benefit:** 75% = $140.55 85% = $159.25

47426	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $281.10 **Benefit:** 75% = $210.85 85% = $238.95
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $468.50 **Benefit:** 75% = $351.40
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $358.55 **Benefit:** 75% = $268.95 85% = $304.80
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $570.45 **Benefit:** 75% = $427.85
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $713.00 **Benefit:** 75% = $534.75
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.) **Fee:** $195.60 **Benefit:** 75% = $146.70 85% = $166.30
47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $293.30 **Benefit:** 75% = $220.00
47450	HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) **Fee:** $391.10 **Benefit:** 75% = $293.35
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.) **Fee:** $471.50 **Benefit:** 75% = $353.65
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.) **Fee:** $228.15 **Benefit:** 75% = $171.15 85% = $193.95
47456	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $342.30 **Benefit:** 75% = $256.75 85% = $291.00
47459	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (Assist.) **Fee:** $456.30 **Benefit:** 75% = $342.25
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes.) **Fee:** $195.60 **Benefit:** 75% = $146.70 85% = $166.30
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47467	STERNUM, treatment of fracture of, by open reduction (Anaes.) **Fee:** $195.60 **Benefit:** 75% = $146.70
47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10 85% = $318.55
47471	RIBS (1 or more), treatment of fracture of - each attendance **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55

47477	PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47480	PELVIC RING, treatment of fracture of, requiring traction (Anaes.) (Assist.) **Fee:** $407.35 **Benefit:** 75% = $305.55
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.) **Fee:** $488.85 **Benefit:** 75% = $366.65
47486	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes.) (Assist.) **Fee:** $814.85 **Benefit:** 75% = $611.15
47489	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Anaes.) (Assist.) **Fee:** $1,222.25 **Benefit:** 75% = $916.70
47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.) **Fee:** $407.35 **Benefit:** 75% = $305.55 85% = $346.25
47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.) (Assist.) **Fee:** $611.05 **Benefit:** 75% = $458.30
47501	ACETABULUM, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes.) (Assist.) **Fee:** $814.85 **Benefit:** 75% = $611.15
47504	ACETABULUM, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes.) (Assist.) **Fee:** $1,222.25 **Benefit:** 75% = $916.70 85% = $1,160.75
47507	ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes.) (Assist.) **Fee:** $1,222.25 **Benefit:** 75% = $916.70
47510	ACETABULUM, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes.) (Assist.) **Fee:** $1,222.25 **Benefit:** 75% = $916.70
47513	SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10 85% = $318.55
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $749.65 **Benefit:** 75% = $562.25
47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.) **Fee:** $749.65 **Benefit:** 75% = $562.25
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $831.05 **Benefit:** 75% = $623.30

47534	FEMUR, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Anaes.) (Assist.) **Fee:** $937.00 **Benefit:** 75% = $702.75
47537	FEMUR, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10 85% = $318.55
47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes.) **Fee:** $187.35 **Benefit:** 75% = $140.55 85% = $159.25
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.) **Fee:** $195.60 **Benefit:** 75% = $146.70 85% = $166.30
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) **Fee:** $293.30 **Benefit:** 75% = $220.00 85% = $249.35
47549	TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $391.10 **Benefit:** 75% = $293.35
47552	TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50 85% = $277.10
47555	TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.) **Fee:** $488.85 **Benefit:** 75% = $366.65
47558	TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
47561	TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies (Anaes.) **Fee:** $236.25 **Benefit:** 75% = $177.20 85% = $200.85
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) **Fee:** $354.45 **Benefit:** 75% = $265.85 85% = $301.30
47565	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $616.55 **Benefit:** 75% = $462.45
47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $785.90 **Benefit:** 75% = $589.45
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $411.40 **Benefit:** 75% = $308.55 85% = $349.90
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $472.55 **Benefit:** 75% = $354.45 85% = $411.05
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes.) (Assist.) **Fee:** $590.70 **Benefit:** 75% = $443.05
47576	FIBULA, treatment of fracture of (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.) **Fee:** $138.55 **Benefit:** 75% = $103.95 85% = $117.80
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $366.75 **Benefit:** 75% = $275.10

47588	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45
47591	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) **Fee:** $1,385.30 **Benefit:** 75% = $1,039.00
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.) **Fee:** $187.35 **Benefit:** 75% = $140.55 85% = $159.25
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $281.10 **Benefit:** 75% = $210.85 85% = $238.95
47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $488.85 **Benefit:** 75% = $366.65
47606	CALCANEUM OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $354.45 **Benefit:** 75% = $265.85 85% = $301.30
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $407.35 **Benefit:** 75% = $305.55 85% = $346.25
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $509.35 **Benefit:** 75% = $382.05
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $354.45 **Benefit:** 75% = $265.85 85% = $301.30
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $488.85 **Benefit:** 75% = $366.65
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes.) **Fee:** $138.55 **Benefit:** 75% = $103.95 85% = $117.80
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $293.30 **Benefit:** 75% = $220.00 85% = $249.35
47633	METATARSAL, 1 of, treatment of fracture of (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $195.60 **Benefit:** 75% = $146.70 85% = $166.30
47642	METATARSALS, 2 of, treatment of fracture of (Anaes.) **Fee:** $130.45 **Benefit:** 75% = $97.85 85% = $110.90
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $195.60 **Benefit:** 75% = $146.70 85% = $166.30

47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $260.60 **Benefit:** 75% = $195.45
47651	METATARSALS, 3 or more of, treatment of fracture of (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $407.35 **Benefit:** 75% = $305.55
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $122.25 **Benefit:** 75% = $91.70 85% = $103.95
47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47681	SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
I 47684	SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, with immobilisation by calipers (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95 85% = $590.40
I 47687	SPINE, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, with immobilisation by calipers, and including up to 14 days post-operative care (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45
I 47690	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, with immobilisation by calipers, requiring reduction by closed manipulation (Anaes.) (Assist.) **Fee:** $896.25 **Benefit:** 75% = $672.20
I 47693	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, with immobilisation by calipers, requiring reduction by closed manipulation, including up to 14 days post-operative care (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45
47696	SPINE, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50 85% = $277.10
47699	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (Anaes.) (Assist.) **Fee:** $1,303.70 **Benefit:** 75% = $977.80
47702	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, requiring open reduction with or without internal fixation, including up to 14 days post-operative care (Anaes.) (Assist.) **Fee:** $1,629.65 **Benefit:** 75% = $1,222.25
47703	SKULL, treatment of fracture of, each attendance **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
47705	SKULL CALIPERS, insertion of, as an independent procedure (Anaes.) (Assist.) **Fee:** $244.35 **Benefit:** 75% = $183.30
47708	PLASTER JACKET, application of, as an independent procedure (Anaes.) **Fee:** $187.35 **Benefit:** 75% = $140.55 85% = $159.25
47711	HALO, application of, as an independent procedure (Anaes.) (Assist.) **Fee:** $277.15 **Benefit:** 75% = $207.90

47714	HALO, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) **Fee:** $207.75 **Benefit:** 75% = $155.85
47717	HALO-THORACIC TRACTION - application of both halo and thoracic jacket (Anaes.) (Assist.) **Fee:** $366.75 **Benefit:** 75% = $275.10
47720	HALO-FEMORAL TRACTION, as an independent procedure (Anaes.) (Assist.) **Fee:** $366.75 **Benefit:** 75% = $275.10 85% = $311.75
47723	HALO-FEMORAL TRACTION, in conjunction with a major spine operation (Anaes.) (Assist.) **Fee:** $366.75 **Benefit:** 75% = $275.10 85% = $311.75
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.) **Fee:** $122.25 **Benefit:** 75% = $91.70
47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50
47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
47738	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.) **Fee:** $415.70 **Benefit:** 75% = $311.80
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $351.95 **Benefit:** 75% = $264.00
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $351.95 **Benefit:** 75% = $264.00
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) **Fee:** $206.70 **Benefit:** 75% = $155.05 85% = $175.70
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) **Fee:** $339.35 **Benefit:** 75% = $254.55
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) **Fee:** $415.70 **Benefit:** 75% = $311.80
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) **Fee:** $477.55 **Benefit:** 75% = $358.20
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.) **Fee:** $377.10 **Benefit:** 75% = $282.85
47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) **Fee:** $377.10 **Benefit:** 75% = $282.85
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $490.15 **Benefit:** 75% = $367.65
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $490.15 **Benefit:** 75% = $367.65 85% = $428.65
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) **Fee:** $622.05 **Benefit:** 75% = $466.55

47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) **Fee:** $622.05 **Benefit:** 75% = $466.55
	GENERAL
47900	BONE CYST, injection into or aspiration of (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47903	EPICONDYLITIS, open operation for (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.) **Fee:** $48.90 **Benefit:** 75% = $36.70 85% = $41.60
47906	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47912	PULP SPACE INFECTION, PARONYCHIA of FOOT, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.) **Fee:** $48.90 **Benefit:** 75% = $36.70 85% = $41.60
47915	INGROWING NAIL OF TOE, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
47916	INGROWING NAIL OF TOE, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) **Fee:** $73.70 **Benefit:** 75% = $55.30 85% = $62.65
47918	INGROWING TOENAIL, radical excision of nailbed (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47920	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) **Fee:** $329.55 **Benefit:** 75% = $247.20
47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.) **Fee:** $97.70 **Benefit:** 75% = $73.30 85% = $83.05
47924	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (Anaes.) **Fee:** $32.55 **Benefit:** 75% = $24.45 85% = $27.70
47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital or approved day-hospital facility - per bone (Anaes.) **Fee:** $122.25 **Benefit:** 75% = $91.70
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.) **Fee:** $228.15 **Benefit:** 75% = $171.15
47933	EXOSTOSIS OF SMALL BONE, excision of, including simple removal of bunion and any associated bursa (Anaes.) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
47936	EXOSTOSIS OF LARGE BONE, excision of (Anaes.) (Assist.) **Fee:** $220.00 **Benefit:** 75% = $165.00
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $138.55 **Benefit:** 75% = $103.95
47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55
47954	TENDON, repair of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50 85% = $277.10
47957	TENDON, large, lengthening of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $244.35 **Benefit:** 75% = $183.30

47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) **Fee:** $114.10 **Benefit:** 75% = $85.60 85% = $97.00
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.) **Fee:** $187.35 **Benefit:** 75% = $140.55 85% = $159.25
47966	TENDON OR LIGAMENT, TRANSFER, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $228.15 **Benefit:** 75% = $171.15
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.) **Fee:** $182.25 **Benefit:** 75% = $136.70
47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.) **Fee:** $319.45 **Benefit:** 75% = $239.60
47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) **Fee:** $194.05 **Benefit:** 75% = $145.55
47981	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes.) **Fee:** $130.25 **Benefit:** 75% = $97.70 85% = $110.75
47982	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.) **Fee:** $315.80 **Benefit:** 75% = $236.85
	BONE GRAFTS
48200	FEMUR, bone graft to (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
48203	FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $790.40 **Benefit:** 75% = $592.80
48206	TIBIA, bone graft to (Anaes.) (Assist.) **Fee:** $489.35 **Benefit:** 75% = $367.05
48209	TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $627.40 **Benefit:** 75% = $470.55
48212	HUMERUS, bone graft to (Anaes.) (Assist.) **Fee:** $489.35 **Benefit:** 75% = $367.05
48215	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $627.40 **Benefit:** 75% = $470.55
48218	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.) **Fee:** $489.35 **Benefit:** 75% = $367.05
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
48224	RADIUS OR ULNA, bone graft to (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) **Fee:** $423.70 **Benefit:** 75% = $317.80
48230	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.) **Fee:** $366.75 **Benefit:** 75% = $275.10
48233	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.) **Fee:** $529.65 **Benefit:** 75% = $397.25

48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.) **Fee:** $692.60 **Benefit:** 75% = $519.45
48239	BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $382.90 **Benefit:** 75% = $287.20
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $529.65 **Benefit:** 75% = $397.25
	OSTEOTOMY OR OSTEECTOMY
48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $448.20 **Benefit:** 75% = $336.15
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95
48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $448.20 **Benefit:** 75% = $336.15
48412	HUMERUS, osteotomy or osteectomy of (Anaes.) (Assist.) **Fee:** $545.80 **Benefit:** 75% = $409.35
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $692.60 **Benefit:** 75% = $519.45
48418	TIBIA, osteotomy or osteectomy of (Anaes.) (Assist.) **Fee:** $545.80 **Benefit:** 75% = $409.35 85% = $484.30
48421	TIBIA, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $692.60 **Benefit:** 75% = $519.45
48424	FEMUR OR PELVIS, osteotomy or osteectomy of (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
48427	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $790.40 **Benefit:** 75% = $592.80
	EPIPHYSIODESIS
48500	FEMUR, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95
48503	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95
48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $423.70 **Benefit:** 75% = $317.80
48509	EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.) **Fee:** $774.05 **Benefit:** 75% = $580.55
	SPINE
48600	SPINE, MANIPULATION OF, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $81.35 **Benefit:** 75% = $61.05

48603	SPINE, manipulation of, under epidural anaesthesia, with or without steroid injection, where the manipulation and the administration of the epidural anaesthetic are performed by the same medical practitioner in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which item 48600 or 50115 applies (Anaes.) **Fee:** $122.25 **Benefit:** 75% = $91.70 85% = $103.95
48606	SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (Anaes.) (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45
48609	SCOLIOSIS or KYPHOSIS, spinal fusion for, using Harrington or other nonsegmental fixation (Anaes.) (Assist.) **Fee:** $1,425.90 **Benefit:** 75% = $1,069.45
48612	SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Anaes.) (Assist.) **Fee:** $2,118.50 **Benefit:** 75% = $1,588.90
48613	SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) **Fee:** $3,013.35 **Benefit:** 75% = $2,260.05
48615	SCOLIOSIS, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Anaes.) (Assist.) **Fee:** $382.90 **Benefit:** 75% = $287.20
48618	SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Anaes.) (Assist.) **Fee:** $2,118.50 **Benefit:** 75% = $1,588.90
48621	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Anaes.) (Assist.) **Fee:** $1,385.30 **Benefit:** 75% = $1,039.00
48624	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) **Fee:** $1,711.20 **Benefit:** 75% = $1,283.40
48627	SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Anaes.) (Assist.) **Fee:** $2,199.90 **Benefit:** 75% = $1,649.95
48630	SCOLIOSIS, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement (Anaes.) (Assist.) **Fee:** $2,444.40 **Benefit:** 75% = $1,833.30
48632	SCOLIOSIS, congenital, vertebral resection and fusion for (Anaes.) (Assist.) **Fee:** $1,351.20 **Benefit:** 75% = $1,013.40
48636	PERCUTANEOUS LUMBAR DISCECTOMY, 1 or more levels not being a service associated with intradiscal electrothermal annuloplasty (Anaes.) (Assist.) *(See para T8.100 of explanatory notes to this Category)* **Fee:** $700.65 **Benefit:** 75% = $525.50 85% = $639.15
48639	VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixation (Anaes.) (Assist.) **Fee:** $1,181.40 **Benefit:** 75% = $886.05
48640	VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) **Fee:** $3,013.35 **Benefit:** 75% = $2,260.05
48642	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Anaes.) (Assist.) **Fee:** $692.60 **Benefit:** 75% = $519.45
48645	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Anaes.) (Assist.) **Fee:** $937.00 **Benefit:** 75% = $702.75
48648	SPINE, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Anaes.) (Assist.) **Fee:** $937.00 **Benefit:** 75% = $702.75

48651	SPINE, bone graft to, (postero-lateral fusion) - more than 2 levels (Anaes.) (Assist.) **Fee:** $1,303.70 **Benefit:** 75% = $977.80
48654	SPINAL FUSION (posterior interbody), with laminectomy, 1 level (Anaes.) (Assist.) **Fee:** $937.00 **Benefit:** 75% = $702.75
48657	SPINAL FUSION (posterior interbody), with laminectomy, more than 1 level (Anaes.) (Assist.) **Fee:** $1,303.70 **Benefit:** 75% = $977.80
48660	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (Anaes.) (Assist.) **Fee:** $937.00 **Benefit:** 75% = $702.75
48663	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.) **Fee:** $700.65 **Benefit:** 75% = $525.50
48666	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) **Fee:** $423.70 **Benefit:** 75% = $317.80
48669	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (Anaes.) (Assist.) **Fee:** $1,262.95 **Benefit:** 75% = $947.25
48672	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.) **Fee:** $945.30 **Benefit:** 75% = $709.00
48675	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) **Fee:** $570.45 **Benefit:** 75% = $427.85
48678	SPINE, simple internal fixation of, involving 1 or more of facetal screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $489.35 **Benefit:** 75% = $367.05
48681	SPINE, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $814.85 **Benefit:** 75% = $611.15
48684	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies - 1 or 2 levels (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $814.85 **Benefit:** 75% = $611.15
48687	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 3 or 4 levels (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $1,140.60 **Benefit:** 75% = $855.45
48690	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - more than 4 levels (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $1,303.70 **Benefit:** 75% = $977.80
	SHOULDER
48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.) **Fee:** $244.35 **Benefit:** 75% = $183.30 85% = $207.70
48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.) **Fee:** $488.85 **Benefit:** 75% = $366.65

48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Anaes.) (Assist.) **Fee:** $488.85 **Benefit:** 75% = $366.65
48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
48912	SHOULDER, arthrotomy of (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50
48915	SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.) **Fee:** $1,303.70 **Benefit:** 75% = $977.80
48921	SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.) **Fee:** $1,344.40 **Benefit:** 75% = $1,008.30
48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.) **Fee:** $1,548.20 **Benefit:** 75% = $1,161.15
48927	SHOULDER prosthesis, removal of (Anaes.) (Assist.) **Fee:** $317.70 **Benefit:** 75% = $238.30
48930	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
48933	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.) **Fee:** $855.60 **Benefit:** 75% = $641.70
48936	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
48939	SHOULDER, arthrodesis of (Anaes.) (Assist.) **Fee:** $937.00 **Benefit:** 75% = $702.75
48942	SHOULDER, arthrodesis of, including removal of prosthesis, requiring bone grafting or internal fixation (Anaes.) (Assist.) **Fee:** $1,222.25 **Benefit:** 75% = $916.70
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20
48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $529.65 **Benefit:** 75% = $397.25
48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $774.05 **Benefit:** 75% = $580.55
48954	SHOULDER, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $814.85 **Benefit:** 75% = $611.15
48957	SHOULDER, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $937.00 **Benefit:** 75% = $702.75

48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $814.85 **Benefit:** 75% = $611.15
	ELBOW
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95
49103	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.) **Fee:** $611.05 **Benefit:** 75% = $458.30
49106	ELBOW, arthrodesis of (Anaes.) (Assist.) **Fee:** $814.85 **Benefit:** 75% = $611.15 85% = $753.35
49109	ELBOW, total synovectomy of (Anaes.) (Assist.) **Fee:** $611.05 **Benefit:** 75% = $458.30
49112	ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.) **Fee:** $611.05 **Benefit:** 75% = $458.30
49115	ELBOW, total joint replacement of (Anaes.) (Assist.) **Fee:** $977.70 **Benefit:** 75% = $733.30
49118	ELBOW, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20
49121	ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $529.65 **Benefit:** 75% = $397.25
	WRIST
49200	WRIST, arthrodesis of, including bone graft, with or without internal fixation of the radiocarpal joint (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $708.80 **Benefit:** 75% = $531.60
49203	WRIST, limited arthrodesis of the intercarpal joint, including bone graft (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $529.65 **Benefit:** 75% = $397.25
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $488.85 **Benefit:** 75% = $366.65
49209	WRIST, total replacement arthroplasty of (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $651.90 **Benefit:** 75% = $488.95
49212	WRIST, arthrotomy of (Anaes.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $203.75 **Benefit:** 75% = $152.85
49215	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $562.30 **Benefit:** 75% = $421.75
49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $236.25 **Benefit:** 75% = $177.20

49221	WRIST, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $529.65 **Benefit:** 75% = $397.25
49224	WRIST, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $611.05 **Benefit:** 75% = $458.30
49227	WRIST, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $611.05 **Benefit:** 75% = $458.30
	HIP
49300	SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
49303	HIP, arthrotomy of, including lavage, drainage or biopsy when performed (Anaes.) (Assist.) **Fee:** $472.55 **Benefit:** 75% = $354.45
49306	HIP arthrodesis of (Anaes.) (Assist.) **Fee:** $937.00 **Benefit:** 75% = $702.75
49309	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
49312	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.) **Fee:** $814.85 **Benefit:** 75% = $611.15
49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.) **Fee:** $733.40 **Benefit:** 75% = $550.05
49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45
49319	HIP, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,003.80 **Benefit:** 75% = $1,502.85
49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,385.30 **Benefit:** 75% = $1,039.00
49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,629.65 **Benefit:** 75% = $1,222.25
49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,874.05 **Benefit:** 75% = $1,405.55
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,874.05 **Benefit:** 75% = $1,405.55
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,118.50 **Benefit:** 75% = $1,588.90
49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.) (Assist.) **Fee:** $309.55 **Benefit:** 75% = $232.20

49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.) **Fee:** $2,403.60 **Benefit:** 75% = $1,802.70
49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.) **Fee:** $2,403.60 **Benefit:** 75% = $1,802.70
49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.) **Fee:** $2,851.80 **Benefit:** 75% = $2,138.85
49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.) **Fee:** $733.40 **Benefit:** 75% = $550.05
49360	HIP, diagnostic arthroscopy of (Anaes.) (Assist.) **Fee:** $297.70 **Benefit:** 75% = $223.30
49363	HIP, diagnostic arthroscopy of, with synovial biopsy (Anaes.) (Assist.) **Fee:** $358.50 **Benefit:** 75% = $268.90 85% = $304.75
49366	HIP, arthroscopic surgery of (Anaes.) (Assist.) **Fee:** $529.65 **Benefit:** 75% = $397.25
	KNEE
49500	KNEE, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50
49503	KNEE, meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello-femoral stabilisation or single transfer of ligament or tendon or any other single procedure (not being a service to which another item in this Group applies) - any 1 procedure (Anaes.) (Assist.) **Fee:** $423.70 **Benefit:** 75% = $317.80
49506	KNEE, meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello-femoral stabilisation or single transfer of ligament or tendon or any other single procedure (not being a service to which another item in this Group applies) - any 2 or more procedures (Anaes.) (Assist.) **Fee:** $635.55 **Benefit:** 75% = $476.70
49509	KNEE, total synovectomy or arthrodesis of (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
49512	KNEE, arthrodesis of, with removal of prosthesis (Anaes.) (Assist.) **Fee:** $937.00 **Benefit:** 75% = $702.75
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.) **Fee:** $733.40 **Benefit:** 75% = $550.05
49517	KNEE, hemiarthroplasty of (Anaes.) (Assist.) **Fee:** $1,044.05 **Benefit:** 75% = $783.05
49518	KNEE, total replacement arthroplasty of (Anaes.) (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45
49519	KNEE, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,003.80 **Benefit:** 75% = $1,502.85
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,385.30 **Benefit:** 75% = $1,039.00
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,629.65 **Benefit:** 75% = $1,222.25

49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,385.30 **Benefit:** 75% = $1,039.00
49530	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,711.20 **Benefit:** 75% = $1,283.40
49533	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,955.60 **Benefit:** 75% = $1,466.70
49534	KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.) **Fee:** $389.00 **Benefit:** 75% = $291.75
49536	KNEE, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed (Anaes.) (Assist.) **Fee:** $814.85 **Benefit:** 75% = $611.15
49539	KNEE, reconstructive surgery of cruciate ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $814.85 **Benefit:** 75% = $611.15
49542	KNEE, reconstructive surgery to cruciate ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed (Anaes.) (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45
49545	KNEE, revision arthrodesis of (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
49548	KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.) **Fee:** $814.85 **Benefit:** 75% = $611.15
49551	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45
49554	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.) **Fee:** $1,629.65 **Benefit:** 75% = $1,222.25
49557	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20
49558	KNEE, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20
49559	KNEE, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $353.70 **Benefit:** 75% = $265.30
49560	KNEE, arthroscopic surgery of, involving 1 or more of: meniscectomy, removal of loose body or lateral release - not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $477.40 **Benefit:** 75% = $358.05
49561	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chrondoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $583.40 **Benefit:** 75% = $437.55
49562	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $636.55 **Benefit:** 75% = $477.45

49563	KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $689.45 **Benefit:** 75% = $517.10
49564	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer (Anaes.) (Assist.) **Fee:** $795.35 **Benefit:** 75% = $596.55
49566	KNEE, arthroscopic total synovectomy of (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
	ANKLE
49700	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20
49703	ANKLE, arthroscopic surgery of (Anaes.) (Assist.) **Fee:** $529.65 **Benefit:** 75% = $397.25
49706	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95
49709	ANKLE, ligamentous stabilisation of (Anaes.) (Assist.) **Fee:** $611.05 **Benefit:** 75% = $458.30
49712	ANKLE, arthrodesis of (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
49715	ANKLE, total joint replacement of (Anaes.) (Assist.) **Fee:** $977.70 **Benefit:** 75% = $733.30
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50
49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.) **Fee:** $570.45 **Benefit:** 75% = $427.85
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.) **Fee:** $244.35 **Benefit:** 75% = $183.30
	FOOT
49800	FOOT, flexor or extensor tendon, primary repair of (Anaes.) **Fee:** $114.10 **Benefit:** 75% = $85.60 85% = $97.00
49803	FOOT, flexor or extensor tendon, secondary repair of (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes.) **Fee:** $114.10 **Benefit:** 75% = $85.60 85% = $97.00
49809	FOOT, open tenotomy of, with or without tenoplasty (Anaes.) **Fee:** $187.35 **Benefit:** 75% = $140.55
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10
49815	FOOT, triple arthrodesis of (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95

49818	FOOT, excision of calcaneal spur (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.) (Assist.) **Fee:** $655.95 **Benefit:** 75% = $492.00
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.) **Fee:** $407.35 **Benefit:** 75% = $305.55
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.) **Fee:** $713.00 **Benefit:** 75% = $534.75
49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - unilateral (Anaes.) (Assist.) **Fee:** $448.20 **Benefit:** 75% = $336.15
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - bilateral (Anaes.) (Assist.) **Fee:** $774.05 **Benefit:** 75% = $580.55
49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, including internal fixation where performed - unilateral (Anaes.) (Assist.) **Fee:** $560.20 **Benefit:** 75% = $420.15
49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, including internal fixation where performed - bilateral (Anaes.) (Assist.) **Fee:** $967.40 **Benefit:** 75% = $725.55
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.) (Assist.) **Fee:** $448.20 **Benefit:** 75% = $336.15
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.) (Assist.) **Fee:** $774.05 **Benefit:** 75% = $580.55
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint (Anaes.) (Assist.) **Fee:** $407.35 **Benefit:** 75% = $305.55
49848	FOOT, correction of claw or hammer toe (Anaes.) **Fee:** $138.55 **Benefit:** 75% = $103.95 85% = $117.80
49851	FOOT, correction of claw or hammer toe with internal fixation (Anaes.) **Fee:** $179.20 **Benefit:** 75% = $134.40
49854	FOOT, radical plantar fasciotomy or fasciectomy of (Anaes.) (Assist.) **Fee:** $325.95 **Benefit:** 75% = $244.50
49857	FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.) **Fee:** $301.45 **Benefit:** 75% = $226.10
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.) **Fee:** $244.35 **Benefit:** 75% = $183.30
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.) **Fee:** $366.75 **Benefit:** 75% = $275.10
49866	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.) **Fee:** $260.60 **Benefit:** 75% = $195.45
49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (Anaes.) **Fee:** $48.90 **Benefit:** 75% = $36.70 85% = $41.60

	OTHER JOINTS
50100	JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes.) (Assist.) **Fee:** $236.25 **Benefit:** 75% = $177.20 85% = $200.85
50102	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $529.65 **Benefit:** 75% = $397.25
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $270.30 **Benefit:** 75% = $202.75 85% = $229.80
50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $407.35 **Benefit:** 75% = $305.55
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $407.35 **Benefit:** 75% = $305.55
50112	CICATRICIAL FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $312.50 **Benefit:** 75% = $234.40
50115	JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $122.25 **Benefit:** 75% = $91.70 85% = $103.95
50118	SUBTALAR JOINT, arthrodesis of (Anaes.) (Assist.) **Fee:** $374.75 **Benefit:** 75% = $281.10
50121	GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.) **Fee:** $733.40 **Benefit:** 75% = $550.05
50124	JOINT or other SYNOVIAL CAVITY, aspiration of, injection into, or both of these procedures; payable on not more than 25 occasions in any 12 month period (Anaes.) *(See para T8.103 of explanatory notes to this Category)* **Fee:** $25.60 **Benefit:** 75% = $19.20 85% = $21.80
50125	JOINT OR OTHER SYNOVIAL CAVITY, aspiration of, or injection into, or both of these procedures ***- where it can be demonstrated that a 26th or subsequent treatment (including any treatments to which item 50124 applies) is indicated in a 12 month period*** (Anaes.) *(See para T8.103 of explanatory notes to this Category)* **Fee:** $25.60 **Benefit:** 75% = $19.20 85% = $21.80
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.) **Fee:** $608.00 **Benefit:** 75% = $456.00
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $270.30 **Benefit:** 75% = $202.75
	MALIGNANT DISEASE
50200	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55
50201	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.) **Fee:** $285.15 **Benefit:** 75% = $213.90
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) **Fee:** $358.55 **Benefit:** 75% = $268.95 85% = $304.80

50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $529.65 **Benefit:** 75% = $397.25
50209	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95
50212	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.) (Assist.) **Fee:** $1,425.90 **Benefit:** 75% = $1,069.45
50215	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes.) (Assist.) **Fee:** $1,792.60 **Benefit:** 75% = $1,344.45
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint (Anaes.) (Assist.) **Fee:** $2,363.00 **Benefit:** 75% = $1,772.25
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.) **Fee:** $2,199.90 **Benefit:** 75% = $1,649.95
50224	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes.) (Assist.) **Fee:** $2,444.40 **Benefit:** 75% = $1,833.30 85% = $2,382.90
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.) **Fee:** $2,851.80 **Benefit:** 75% = $2,138.85
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.) **Fee:** $1,466.60 **Benefit:** 75% = $1,099.95
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.) **Fee:** $1,874.05 **Benefit:** 75% = $1,405.55
50236	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.) **Fee:** $1,466.60 **Benefit:** 75% = $1,099.95
50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $977.70 **Benefit:** 75% = $733.30
	LIMB LENGTHENING AND DEFORMITY CORRECTION
50300	JOINT DEFORMITY, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes.) (Assist.) **Fee:** $1,001.90 **Benefit:** 75% = $751.45
I 50303	LIMB LENGTHENING, 5cm or less, by gradual distraction, with application of an external fixator or intra-medullary device, in the operating theatre of a hospital or approved day-hospital facility, - payable only once per limb in any 12 month period (Anaes.) (Assist.) **Fee:** $1,367.90 **Benefit:** 75% = $1,025.95
I 50306	LIMB LENGTHENING , where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity, or where the lengthening is greater than 5cm (Anaes.) (Assist.) **Fee:** $2,135.85 **Benefit:** 75% = $1,601.90 85% = $2,074.35
50309	RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility, not being a service to which item 50303 or 50306 applies (Anaes.) (Assist.) **Fee:** $263.95 **Benefit:** 75% = $198.00
50312	ANKLE, synovectomy of (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50

50315	TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.) **Fee:** $599.95 **Benefit:** 75% = $450.00
50318	TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.) **Fee:** $599.95 **Benefit:** 75% = $450.00
50321	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.) **Fee:** $803.90 **Benefit:** 75% = $602.95
50324	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.) **Fee:** $1,145.95 **Benefit:** 75% = $859.50
50327	TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.) **Fee:** $1,397.85 **Benefit:** 75% = $1,048.40
50330	TALIPES EQUINOVARUS, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.) **Fee:** $197.95 **Benefit:** 75% = $148.50 85% = $168.30
50333	TARSAL COALITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.) (Assist.) **Fee:** $533.90 **Benefit:** 75% = $400.45
50336	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.) (Assist.) **Fee:** $798.00 **Benefit:** 75% = $598.50
50339	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.) (Assist.) **Fee:** $486.05 **Benefit:** 75% = $364.55
50342	FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.) (Assist.) **Fee:** $563.90 **Benefit:** 75% = $422.95
50345	HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.) (Assist.) **Fee:** $300.05 **Benefit:** 75% = $225.05
	HIP, KNEE AND LEG PROCEDURES
50348	KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $197.95 **Benefit:** 75% = $148.50 85% = $168.30
+ 50349	HIP, congenital dislocation of, treatment of, by closed reduction (Anaes.) **Fee:** $277.15 **Benefit:** 75% = $207.90 85% = $235.60
+ 50351	HIP, developmental dislocation of, open reduction of (Anaes.) (Assist.) **Fee:** $1,382.30 **Benefit:** 75% = $1,036.75 85% = $1,320.80
50352	HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.) **Fee:** $48.90 **Benefit:** 75% = $36.70 85% = $41.60
50353	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.) (Assist.) **Fee:** $307.05 **Benefit:** 75% = $230.30
50354	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.) **Fee:** $1,133.90 **Benefit:** 75% = $850.45 85% = $1,072.40
50357	KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes.) (Assist.) **Fee:** $486.05 **Benefit:** 75% = $364.55
50360	KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.) **Fee:** $563.90 **Benefit:** 75% = $422.95
50363	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes.) (Assist.) **Fee:** $431.95 **Benefit:** 75% = $324.00

50366	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.) (Assist.) **Fee:** $755.95 **Benefit:** 75% = $567.00
50369	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.) **Fee:** $563.90 **Benefit:** 75% = $422.95
50372	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.) **Fee:** $989.90 **Benefit:** 75% = $742.45
50375	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes.) (Assist.) **Fee:** $431.95 **Benefit:** 75% = $324.00
50378	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Anaes.) (Assist.) **Fee:** $755.95 **Benefit:** 75% = $567.00
50381	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Anaes.) (Assist.) **Fee:** $563.90 **Benefit:** 75% = $422.95
50384	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Anaes.) (Assist.) **Fee:** $989.90 **Benefit:** 75% = $742.45
50387	HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer of adductors to ischium (Anaes.) (Assist.) **Fee:** $563.90 **Benefit:** 75% = $422.95
50390	PERTHES, CEREBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $197.95 **Benefit:** 75% = $148.50 85% = $168.30
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.) **Fee:** $731.90 **Benefit:** 75% = $548.95
50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.) **Fee:** $2,403.60 **Benefit:** 75% = $1,802.70
50396	***SHOULDER, ARM AND FOREARM PROCEDURES*** HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.) (Assist.) **Fee:** $402.05 **Benefit:** 75% = $301.55
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.) **Fee:** $798.00 **Benefit:** 75% = $598.50
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.) **Fee:** $366.00 **Benefit:** 75% = $274.50
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.) **Fee:** $497.95 **Benefit:** 75% = $373.50
50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.) **Fee:** $863.95 **Benefit:** 75% = $648.00
50411	***AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES*** LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.) **Fee:** $1,133.90 **Benefit:** 75% = $850.45 85% = $1,072.40

50414	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.) **Fee:** $1,529.85 **Benefit:** 75% = $1,147.40 85% = $1,468.35
50417	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.) (Assist.) **Fee:** $1,133.90 **Benefit:** 75% = $850.45 85% = $1,072.40
50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.) **Fee:** $935.90 **Benefit:** 75% = $701.95
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) **Fee:** $863.95 **Benefit:** 75% = $648.00 85% = $802.45
	TUMOROUS CONDITIONS
50426	DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.) **Fee:** $402.05 **Benefit:** 75% = $301.55
	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:** $707.20 **Benefit:** 75% = $530.40 85% = $645.70
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 T8.104 of explanatory notes to this Category)* **Fee:** $707.20 **Benefit:** 75% = $530.40 85% = $645.70

GROUP T9 - ASSISTANCE AT OPERATIONS

NOTE: *Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more than one medical practitioner.*

I 51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed $483.20 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $483.20 *(See para T9.2 of explanatory notes to this Category)* **Fee:** $74.70 **Benefit:** 75% = $56.05 85% = $63.50
I 51303	Assistance at any operation identified by the word "Assist." for which the fee exceeds $483.20 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds $483.20 *(See para T9.3 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations
51306	Assistance at a delivery involving Caesarean section **Fee:** $107.95 **Benefit:** 75% = $81.00 85% = $91.80
51309	Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section *(See para T9.4 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 **Derived Fee:** one fifth of the established fee for the procedure or combination of procedures
51315	Assistance at cataract and intraocular lens surgery covered by item 42698,42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42746, 42749, 42752, 42776 or 42779 **Fee:** $235.70 **Benefit:** 75% = $176.80 85% = $200.35
51318	Assistance at cataract and intraocular lens surgery where patient has: - total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or - pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30

INDEX TO
GENERAL MEDICAL SERVICES

PLEASE NOTE:

This index is a reference point for medical services which attract Medicare benefits under items included in the Schedule of General Medical Services. Medical practitioners should peruse the actual description of the item in the Schedule to ensure the correct item number is selected and to ascertain whether there are any restrictions relating to the payment of benefits. Restrictions are, as far as practicable, included in the description of the item. Otherwise they will be outlined in the notes immediately preceding the particular Category of the Schedule.

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*** Payable on attendance basis**

Service	Item
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*** Payable on attendance basis**

Service	Item
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of haematoma	30216
of joint, other synovial cavity (restriction)	50124,50125
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B	
Baker's cyst, excision of	30114
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*** Payable on attendance basis**

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*** Payable on attendance basis**

Service	Item
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rectum, resection of	32024-32028
resection for enterocolitis stricture, neonatal	43834
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small, strictureplasty	30564
Brachial plexus, exploration of	39333
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Brachycephaly, cranial vault reconstruction for	45785
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stem tumour, craniotomy for removal	39709
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Broad ligament cyst/tumour, excision/removal	35712-35717
Brodie's abscess, operation for	43515
Bronchial tree, intrathoracic operation on, other	38456
Bronchoscopy, as an independent procedure	41889
with biopsy or other procedure	41892
with dilatation of tracheal stricture	41904
with transbronchial lung biopsy	41898
Bronchospirometry	11500
Bronchus, dilatation of stricture and stent insertion	41905
operations on	41889,41892,41895
removal of foreign body in	41895
Broviac catheter, insertion of, for chemotherapy	34527,34528
catheter, removal of	34530
Bubonocele operation	30612,30614
Bunion, excision of	47933
Burch colposuspension	37044
Burns, dressing of (not involving grafting)	30003-30014
excision of under GA (not involving grafting)	30017,30020
free grafting	45406-45494
scars, excision of	45519
Burr-hole craniotomy, intracranial haemorrhage	39600
placement of intracranial electrodes	40709
single, preparatory to ventricular puncture	39012
Bursa, incision of	*
large, excision of	30110,30111
semimembranosus, excision of	30114
small, excision of	30106,30107
Burst abdomen, repair of	30403
Bypass, extracranial to intracranial	39818
graft, infected, of extremities, excision of	34175
graft, infected, of neck, excision of	34157
graft, infected, of trunk, excision of	34169
grafting for aneurysm	33050,33055
grafting, arterial, for occlusive arterial disease	32700-32763
grafting, cross leg, saphenous to iliac or femoral vein	34806

C

C-13 or C-14 urea breath test	12533
Caecostomy,	30375
closure of	30562
Caesarean section	16520,16522
Calcaneal spur, of foot, excision of	49818
Calcanean bursa, excision of	30110,30111
Calcaneum fracture, treatment of	47606-47618
Calculus, biliary, extraction of	30454-30458
biliary/renal tract, extraction of	30450
bladder, removal of	36863
kidney, removal of	36540,36543
renal, extraction of	36627-36648
staghorn, nephrolithotomy and/or pyelolithotomy	36543
sublingual/salivary gland duct, removal of	30265,30266
ureter, removal of	36549
ureteric, endoscopic removal/manipulation	36857
Caldwell-Luc operation	41710
Calf, decompression fasciotomy of	47975,47978,47981
Caloric test of labyrinth(s)	11333,11336
Cancer of skin/mucous membrane, removal	30196-30205
Cannulae, membrane oxygenation	38627
bypass	38627
ventricular assist	38627
Cannulation, arterial, for infusion chemotherapy	34524
central vein	13318,13815
central vein, subcutaneous tunnel	34527
coronary sinus, for admin of blood or crystalloid	38588
for cardiopulmonary bypass	38600,38603
for retrograde cerebral perfusion	38577
intra-abdominal vessel, for chemotherapy	34521
peripheral arterial	35317-35321
peripheral venous	35317,35319,35320
pulmonary artery	13818
umbilical artery	13303
umbilical/scalp vein in neonate	13300
Canthoplasty	42590
Capsule endoscopy, for obscure gastrointestinal bleeding	11820
Capsule, posterior, needling of	42737
Capsulectomy	42719,42722,42731
of finger joints	46336
Capsulotomy, laser	42788,42789
other than laser	42734
Carbolisation of eye	*
Carbon dioxide laser resurfacing, face or neck	45025,45026
dioxide output, estimation of	11503
labelled urea breath test	12533
Carbuncle, incision and drainage, with GA	30223
Carcinoma	(see tumour)

*** Payable on attendance basis**

Service	Item
Cardiac by-pass, whole body perfusion	22060
catheterisation	38200-38218
catheterisation - for myocardial biopsy	38275
deep hypothermic circulatory arrest	22075
electrophysiological studies	38209,38212,38213
operation (intrathoracic), other	38456
pacemaker, insertion/replacement	38353
rhythm, restoration, electrical stimulation	13400
surgery, for congenital heart disease	38700-38766
surgery, re-operation via median sternotomy	38640
tumour, excision of	38670-38680
Cardiopexy, antireflux operation	30530
Cardioplegia, retrograde administration of	22070
Cardiopulmonary bypass, cannulation for	38600,38603
support procedures	13815-13857
Cardiotocography, antenatal (restriction)	16514
Cardioversion	13400
Care planning	721-731
Carotid artery, aneurysm, graft replacement	33100
artery, internal, transection/resection	32703
body tumour, resection of	34148,34151,34154
cavernous fistula, obliteration of	39815
percutaneous transluminal angioplasty with stenting	35307
Carpal bone, replacement arthroplasty	46324,46325
ligament, transverse, division of	39331
resection arthroplasty	46325
scaphoid, fracture, treatment of	47354,47357
tunnel release	39331
Carpometacarpal joint, arthrodesis of	46303
joint, dislocation, treatment of	47030,47033
joint, synovectomy of	46342
Carpus dislocation, treatment of	47030,47033
fracture, treatment of	47348,47351
operation on, acute osteomyelitis	43503,46462
operation on, chronic osteomyelitis	43512,46462
osteectomy/osteotomy of	48406,48409
Cartilage, tarsal, excision of	42578
excision of, with melanoma	31340
Caruncle, urethral, cauterisation of	35523
urethral, excision of	35526,35527
Case conferencing	740-773
Cataract, juvenile, removal of	42716
surgery	42702
Catheter, peritoneal insertion and fixation	13109
epidural, insertion of	39140
placement of catheters and injection of opaque material	38243
tenckhoff peritoneal dialysis, removal of	13110
Catheterisation, bladder, independent procedure	36800
blood pressure monitoring	13876
cardiac	38200-38218
central vein	13318,13319,13815
central vein, subcutaneous tunnel	34527,34528
central vein, tunnelled cuffed	34538
eustachian tube	41755
frontal sinus	41740
intracranial, for pressure monitoring	13830
peripheral arterial	35317-35321
peripheral venous	35317,35319,35320
peritoneal, for dialysis	13109,13110
pulmonary artery	13818
right heart balloon	13818
umbilical artery	13303
umbilical or scalp vein in a neonate	13300
ureteric, with cystoscopy	36824
Caudal infusion/injection	(see Intrathecal)
Cauterisation, angioma (restriction applies)	45027
cervix	35608
perforation of tympanum	41641
septum/turbinates/pharynx	41674
tarsus, for ectropian/entropian	42581
urethra or urethral caruncle	35523
Cautery, conjunctiva, including treatment of pannus	42677
nasal, for arrest of haemorrhage	41677
Cavernous sinus, tumour or vascular lesion, excision	39660
Cavopulmonary shunt, creation of	38733,38736
Cellulitis, incision with drainage, under GA	30223
Central cannulation for cardiopulmonary bypass	38600
nervous system evoked responses	11024,11027
vein catheterisation	13318,13319,13815
vein catheterisation, via subcutaneous tunnel	34527,34528
Cerebello-pontine angle tumour	41575-41579
- retromastoid removal of	41575-41579
- translabyrinthine removal	41575-41579
- transmastoid removal	41575-41579
Cerebral palsy, hips or knees, application of cast under GA	50390
perfusion, retrograde, cannulation for	38577
tumour, craniotomy for removal	39712
ventricle, puncture of	39006
Cerebrospinal fluid drain, lumbar, insertion of	40018
fluid reservoir, insertion of	39018
Cervical decompression of spinal cord	40331-40335
discectomy (anterior), without fusion	40333
oesophagectomy	30294
oesophagostomy, closure or plastic repair of	30293
re-exploration for hyperparathyroidism	30317
rib, removal of	34139
sympathectomy	35003,35006
Cervix, amputation or repair of	35617,35618
cauterisation of, other than by chemical means	35608
colposcopic examination of	35614
colposcopy with biopsy and diathermy	35646
cone biopsy of	35617,35618
diathermy of	35608,35646
electrocoagulation diathermy	35644,35645
ionisation of	35608
large loop excision	35647,35648
laser therapy (restriction applies)	35539,35542,35545
punch biopsy	35608
purse string ligation	16511
removal of polyp from	35611
removal of purse string ligature	16512
repair of extensive laceration/s	16571
repair of, not otherwise covered	35617,35618
residual stump, removal of, abdominal approach	35612
residual stump, removal of, vaginal approach	35613
Chalazion, extirpation of	42575
Chemical peel, full face	45019,45020
Chemotherapy	13915-13936
device for drug delivery, loading of	13939,13942,13945
device, insertion, central vein catheterisation	34527,34528
device, removal of	34530
infusion, cannulation for	34521,34524
Chest, or limb, decompression escharotomy	45054
Chloasma, full face chemical peel	45019,45020
Choanal atresia, repair/correction	45645,45646
Cholangiogram, percutaneous transhepatic	30440
Cholangiography, operative	30439
Cholangiopancreatography	30484

*** Payable on attendance basis**

Service	Item
Cholecystectomy	30443-30449
Cholecystoduodenostomy	30460,31472
Cholecystoenterostomy	30460,31472
Cholecystostomy	30375
Choledochal cyst, resection of	43972,43975
Choledochoduodenostomy	30460,30461
Choledochoenterostomy	30460,30461
Choledochogastrostomy	30461
Choledochojejunostomy	30460,30461
Choledochoscopy	30442,30452
Choledochotomy	30454,30455,30457
Chondro-cutaneous or chondro-mucosal graft	45656
Chondroplasty of knee	49503,49506
Chordee, correction of	37417
Chorionic villus sampling	16603
Chymopapain (Discase), intradiscal injection of	40336
Cicatricial flexion/extension contracture, joint, correction	50112
Ciliary body and/or iris, excision of tumour	42767
Circulatory support device, management of	13851,13854
support procedures	38600-38624
Circumcision	30653-30660
arrest of post-operative haemorrhage	30663
- with GA	
- without GA	*
Cisternal puncture	39003
shunt diversion, insertion of	40003
shunt, revision or removal of	40009
Clavicle, dislocation, treatment of	47003,47006
fracture, treatment of	47462,47465
operation for acute osteomyelitis	43503
operation for chronic osteomyelitis	43512
osteectomy/osteotomy	48406,48409
Claw toe, correction of	49848
Cleft lip, operations for	45677-45704
palate, correction of	45707,45710,45713
Clitoris, amputation of, medically indicated	35530
Clitoroplasty, reduction, ambiguous genitalia	37845,37848
Clival tumour, removal of	39653-39658
Cloaca, persistent, correction of	43969
Cloacal exstrophy, neonatal, operation for	43882
Club hand, radial, centralisation/radialisation	50399
Coccyx, excision of	30672
Cochlear implant, insertion with mastoidectomy	41617
tests	11318,11321
Cochleotomy, or repair of round window	41614
Coeliac artery, decompression of	34142
Colectomy, subtotal, of large intestine	32004,32005
total, for Hirschsprung's, paediatric	43996
total, with excision rectum/anastomosis	32051,32054,32057
total, with excision rectum/ileostomy	32015,32018,32021
total, with ileo-rectal anastomosis	32012
total, with ileostomy	32009
Colles' fracture of radius, treatment of	47369,47372,47375
Colonic atresia, neonatal, laparotomy for	43816
lavage, total, intra-operative	32186
reservoir, construction of	32029
Colonoscopy, fibreoptic	32084-32093
Colorectal strictures, endoscopic dilatation of	32094
Colostomy, closure of	30562
colostomy	30375
entero-	30515
lavage of	*
refashioning of	30563
with laparotomy, neonatal anorectal malformation	43822
Colotomy	30375
Colour discrimination test, Farnsworth Munsell	*
Colpoperineorrhaphy	35571,35573
Colpopexy, sacral	35597
sacrospinous	35568
Colposcopy, using Hinselmann-type instrument	35614
with other procedures	35644-35647
Colpotomy	35572
Composite graft to nose, ear or eyelid	45656
Computerised perimetry	11221-11225
Condylectomy	45611,48406,48424
of mandible	45611
Condylectomy/condylotomy	45863
Cone biopsy of cervix	35617,35618
Confinement	16515-16525
Congenital absence of vagina, reconstruction for	35565
atresia, auditory canal reconstruction	45662
heart disease, operations for	38700-38766
Conjunctiva, cautery of	42677
biopsy of	42676
cryotherapy to	42680
removal of tumour from	(see tumour,other)
Conjunctival cysts, removal of	42683
graft over cornea	42638
lacerations not involving sclera	30032
peritomy	42632
Conjunctivorhinostomy	42629
Consultation	(see attendances)
Contact lenses, attendances	10801-10816
Contour reconstruction, insertion of foreign implant	45051
restoration of face, autologous bone/cartilage graft	45647
Contraceptive device, intra-uterine, introduction of	35503
device, intra-uterine, removal under GA	35506
Contracted socket, reconstruction	42527
Contracture, cicatricial flexion/extension of joint, correction	50112
Dupuytren's, subcutaneous fasciotomy for	46366
flexor/extensor, digits of hand, correction of	46492
Cordotomy, laminectomy for	39124
percutaneous	39121
Cornea, conjunctival graft over	42638
epithelial debridement for corneal ulcer/erosion	42650
epithelial debridement for keratoplasty	42651
removal of imbedded foreign body	42644
removal of superficial foreign body	30061
transplantation of	42653,42656,42659
Corneal, laser coagulation of blood vessels	42797
additional incisions for astigmatism	42673
incisions for astigmatism	42672
keratoplasty, epithelial debridement for	42651
perforations, sealing of	42635
scars, excision of	42647
suture, running, manipulation of	42667
sutures, removal of	42668
ulcer, epithelial debridement of cornea for	42650
ulcer, ionisation of	*
Coronary artery bypass operations	38497-38504
angiography, selective	38215-38246
artery bypass vein graft, dissection	38637
endarterectomy, open operation	38505
restensoses, catheter based intravascualar brachytherapy for	35347-35356
Corpus callosum, anterior section of, for epilepsy	40700
Corticectomy, for epilepsy	40703
Corticolysis of lens material	42791,42792
Costo-transverse joint, injection into	39013

*** Payable on attendance basis**

Service	Item
Counterpulsation, intra-aortic balloon, management	13848,13847
Cranial nerve, intracranial decompression of	39112
shunt diversion, insertion of	40003
shunt, revision or removal of	40009
vault reconstruction	45785
Craniectomy and removal of haematoma	39603
for osteomyelitis/removal infected bone	39906
Craniocervical junction lesion, transoral approach for	40315
Craniopharyngioma, craniotomy for removal of	39712
Cranioplasty and repair of fractured skull	39615
reconstructive	40600
Craniostenosis, operations for	40115,40118
Craniotomy and tumour removal	39709,39712
burr-hole for intracranial haemorrhage	39600
for arachnoidal cyst	39718
for hydromyelia (with laminectomy)	40342
for reopening post-op for haemorrhage/swelling	39721
Cricopharyngeal myotomy	41776
Cricothyrostomy	41884
Cruciate ligaments, reconstruction/repair	49536,49539,49542
Cryotherapy for detached retina	42773
for trichiasis	42587
hepatic, destruction of liver tumours	30419
of peripheral nerves	39323
of retina, with vitrectomy	42728
of skin lesions	30189,30192,30195
to haemorrhoids with rubber band ligation	32135
to nose, for haemorrhage	41680
to retina, independent procedure	42818
Crystalloid, retrograde admin for cardioplegia	38588
Curettage, for evacuation of gravid uterus	35643
uterus (D and C)	35639,35640
Cutaneous neoplastic lesions, treatment of	30195
nerve, nerve graft to	39318
nerve, repair of	39300,39303
ureterostomy, closure of	36621
vesical fistula, operation for	37023
vesicostomy, establishment of	37026
Cyclodestructive procedures treatment of glaucoma	42770,42771
Cyst, arachnoidal, craniotomy for	39718
Baker's, excision of	30114
Bartholin's, cautery destruction of	35516,35517
Bartholin's, excision of	35512,35513
Bartholin's, marsupialisation of	35516,35517
bone, injection into or aspiration of	47900
brain, operations for	39703
branchial, removal of	30286
breast, aspiration of	*
broad ligament, excision of	35712-35717
bronchgenic, thoracotomy and excision	43912
choledochal, resection of	43972,43975
enterogenous, thoracotomy and excision	43912
epididymal, removal of	37601
fimbrial, excision of	35712-35717
hydatid, liver, treatment of	30434-30438
hydatid, lungs, enucleation of	38424
intracranial, needling and drainage of	39703
kidney, removal from	36558
liver, laparoscopic marsupialisation	30416,30417
mucous, of mouth, removal	30282,30283
not otherwise covered, removal of (OMS)	45801-45809
other, removal of	31200-31240
ovarian, aspiration of	35518
ovarian, excision of, with laparotomy	35712-35717
pancreatic, anastomosis	30586,30587
parovarian, excision of, with laparotomy	35712-35717
pharyngeal, removal of	41813
pilonidal, excision of	30675,30676
renal, excision of	36558
skin/subcutaneous/mucous membrane, removal of	31200-31240
tarsal, extirpation of	42575
thyroglossal, removal of	30313,30314
vaginal, excision of	35557
vallecular, removal of	41813
Cystadenomatoid malformation, neonatal, thoracotomy	43861
Cystocoele, repair of	35570
Cystometrography	11903
with other procedures	11912,11915,11917,11919
Cystoscopy, with	36836
- biopsy of bladder	
- controlled hydrodilatation of bladder	36827
- diathermy or resection of bladder tumour/s	36845
- endoscopic incision/resection	36825,36854
- injection into bladder wall	36851
- insertion of ureteric stent, or brush biopsy	36821
- insertion of urethral prosthesis	36811
- laser destruction of bladder tumours	36840
- lavage of blood clots from bladder	36842
- removal of foreign body	36833
- resection of ureterocele	36848
- ureteric catheterisation	36818,36824
- ureteric meatotomy	36830
- urethroscopy with/without urethral dilatation	36812
- without litholapaxy	36863
- without urethroscopy	36815
Cystostomy, suprapubic	37008
suprapubic, change of tube	*
Cystotomy, suprapubic	37008,37011
Cytotoxic agent, instillation into body cavity	13948

D

D and C	35639,35640
Dacryocystectomy	42596
Dacryocystorhinostomy	42623,42626
Dark Adaptometry	11211
Debridement of contaminated wound	30023
of tissue, ischaemic limb	35100,35103
Debulking operation, gynaecological malignancy	35720
Decompression fasciotomy, calf/forearm	47975,47978,47981
fasciotomy, hand	47981
of Arnold-Chiari malformation	40106
of facial nerve, mastoid portion	41569
of intracranial tumour	39706
operation for priapism	37393
subtemporal	40015
Deep organ, percutaneous aspiration biopsy	30094
tissue or organ, biopsy of	30074,30075,30078
Defibrillator generator, insertion/replacement	38393
insertion of patches for	38390
Delorme procedure	32111
Dermabrasion	45021,45024
Dermo-fat or fascia graft	45018
Dermoid, excision of	(see tumour,other)
nasal, excision of	41729
oral and maxillofacial region	45801-45807
orbital, excision of	42574
periorbital, excision of	42573

*** Payable on attendance basis**

Service	Item
Detached retina, diathermy/cryotherapy	42773
retina, removal of silicone band	42812
retina, resection/buckling/revision	42776
Dialysis, peritoneal	13112
supervision in home	13104
supervision in hospital	13100,13103
Diaphragm, plication of for eventration	43915
Diaphragmatic hernia, neonatal, repair of	43837,43840
hernia, repair of	30600,30601
hernia, simple closure of	30387
Diaphyseal aclasia, removal of lesion/s from bone	50426
Diastematomyelia, tethered cord, release of	40112
Diathermy of bladder tumours	36845,36840
cervix	35608,35646
detached retina	42773
electrocoagulation, of cervix	35644,35645
palmar or plantar wart	30186
perforation of tympanum	41641
pharynx	41674
rectal polyps with sigmoidoscopy	32078
salivary gland duct	30262
septum	41674
starburst vessels, head or neck	30213,30214
telangiectases, head or neck	30213,30214
turbinates	41674
urethra	37318
Diffusing capacity	11503
Digit, amputation of	46464-46480
distal, excision of ganglion/mucous cyst	46495
extra, amputation of	46464
flexor/extensor contracture, correction of	46492
or ray, transposition/transfer, vascular pedicle	46507
synovectomy of tendon/s	46348-46360
transposition/transfer, vascular pedicle	46507
Digital nail, toe, removal of	47904,47906
nerve, nerve graft to	39318
nerve, repair of	39300,39303
temperature, measurement of	11615
Direct flap repair	45209-45224
Disarticulation, of limb	(see amputation)
Disc, intervertebral, laminectomy for removal	40300
intervertebral, microsurgical discectomy of	40301
lesion, recurrent, laminectomy for	40303
Discectomy, cervical (anterior), without fusion	40333
microsurgical, of intervertebral disc/s	40301
percutaneous lumbar	48636
Disimpaction of faeces under GA	32153
Dislocations, treatment of	(see body part)
Dissection, lymph nodes of neck	31423-31438
Diverticulum, bladder, excision/obliteration	37020
Meckel's, removal of	30375
urethral, excision of	37372
Dohlman's operation	41773
Domiciliary Medication Management Review	900
Donald-Fothergill operation	35577
Donor haemapheresis	13755
Doppler recordings	11612,11602,11610,11611,11614
Double vagina, excision of septum	35566
Drez lesion, operation for	39124
Drill biopsy of lymph gland/deep tissue/organ	30078
Drug delivery device, loading of	13939,13942,13945
Duct, salivary gland, diathermy/dilatation	30262
salivary gland, major, transposition of	41910
salivary gland, marsupialisation	30265,30266
salivary gland, meatotomy	30265,30266
salivary gland, removal of calculus	30265,30266
Ducts submandibular, removal of	30255
Duodenal atresia, duodeno-duodenostomy/jejunostomy	43807
intubation	30487,30488
stenosis, duodeno-duodenostomy/jejunostomy	43807
ulcer, perforated, suture	30375
Duodenoduodenostomy for duodenal atresia/stenosis	43807
Duodenojejunostomy for duodenal atresia/stenosis	43807
Duodenoscopy	30473,30476,30478
Dupuytren's contracture, operations for	46366-46393
Dysthyroid eye disease, decompression of orbit	42545

E

E.C.G.	11700-11713
E.C.T.	14224
E.E.G.	11000,11003,11006,11004,11005
E.M.G.	11012,11021,11833
E.N.G.	11339
ESWL	36546
Ear, composite graft to	45656
drum perforation, excision of rim	41644
external, complex total reconstruction of	45660,45661
full thickness laceration, repair of	30052
full thickness wedge excision of	45665
lop, bat or similar deformity, correction of	45659
middle, clearance of	41635,41638
middle, exploration of	41629
middle, insertion of tube for drainage of	41632
middle, operation for abscess or inflammation of	41626
removal of foreign body from	41500,41503
syringe of	*
toilet, using operating microscope	41647
ventilating tube, removal	*
Eclampsia, treatment of	16509
Ectopic bladder, 'turning-in' operation	37842
pregnancy, removal of	35676,35677,35678
pregnancy, ultrasound guided needling and injection	35674
Ectropion, correction of	45626
tarsal cauterisation for	42581
Elbow, arthrodesis of	49106
arthroscopic surgery of	49121
arthroscopy of, diagnostic	49118
arthrotomy of	49100
dislocation, treatment of	47018,47021
flexorplasty/tendon transfer to restore function	50405
ligamentous stabilisation of	49103
radial head, replacement of	49112
total replacement of	49115
total synovectomy of	49109
Electrical stimulation, maximal perineal	*
stimulation, restoration cardiac rhythm	13400
Electrocardiography	11700-11713
Electrocochleography	11303,11304
Electroconvulsive therapy	14224
Electrocorticography	11009
Electrode(s), epidural, insertion by laminectomy	39139
epidural, percutaneous insertion of	39130
epidural, percutaneous, management of	39131
graciloplasty, insertion of	32206
intracranial placement	40709,40712
myocardial, permanent, insertion, thoracotomy	38470
pacemaker, permanent, insertion sub xyphoid	38473

*** Payable on attendance basis**

Service	Item
transvenous, insertion of	38256,38356
Electrodiagnosis, neuromuscular	11012-11021
Electroencephalography (E.E.G)	11000,11003,11006,11004,11005
Electrolysis epilation, for trichiasis	42587
Electromyography (E.M.G.)	11012,11021,11833
Electroneurography of facial nerve	11015
Electronystagmography (E.N.G.)	11339
Electrooculography	11205
Electrophysiological studies, cardiac	38209,38212,38213
Electroretinography	11204,11205,11210
Embolectomy	33803,33806
Embolus, removal from artery of neck	33800
Emergency, after hours	1,2,97,98
Emergency, after hours (11pm to 7am)	601,602,697,698
Emphysema, lobar, neonatal, thoracotomy & lung resection	43861
Empyema, intercostal drainage of	38806,38809
radical operation for	38415
Enbloc resection of tumour	50212-50227
Encephalocoele, excision and closure of	40109
Endarterectomy	33500-33542
coronary, open operation	38505
to prepare bypass site for anastomosis	33554
Endobronchial tumour, endoscopic laser resection	41901
Endocarditis, operative management of	38493
Endocrine tumour, exploration of	30578,30580,30581
Endolymphatic sac, transmastoid decompression	41590
Endometrial biopsy for suspected malignancy	35620
Endometriosis, laparoscopic ablation	35638
Laparoscopic resection of	35641
Endometrium, ablation of, endoscopic	35622
biopsy of	*
biopsy of for suspected malignancy	35620
biopsy of with hysteroscopy	35630
biopsy of, with IUD insertion for idiopathic menorrhagia	35502
endoscopic examination and ablation by microwave or thermal balloon	35616
Endoscopic biliary dilatation	30494
cholangio-pancreatography	30484
dilatation of colorectal strictures	32094
examination of intestinal conduit/reservoir	36860
examination of small bowel	30569,32095
gastrostomy, percutaneous	30481,30482
incision/resection, external sphincter/bladder neck	36854
laser ablation of prostate	37207,37208
laser resection of endobronchial tumours	41901
laser therapy of gastrointestinal tract	30479
manipulation/extraction of ureteric calculus	36857
prostatectomy	37203,37206
resection of pharyngeal pouch	41773
sphincterotomy	30485
stenting of bile duct	30491
transanal endoscopic microsurgery	32103,32104,32106
Endoscopy with balloon dilatation gastric stricture	30475
capsule, for obscure gastrointestinal bleeding	11820
Enterocoele, repair of	35571
Enterocolitis, acute neonatal necrotising, laparotomy	43828,43831
necrotising stricture, bowel resection	43834
Enterocolostomy	30515
Enterocutaneous fistula, radical repair of	30382
Enteroenterostomy	30515
Enterostomy, closure of	30562
enterostomy	30375
Enterotomy, intra-operative, for endoscopy	30568
enterotomy	30375
Entropion, correction of	45626
repair of	42866
Enucleation of eye	42506,42509
hydatid cysts of lung	38424
Epicondylitis, open operation for	47903
Epicutaneous patch testing	12012-12021
Epididymal cyst, excision of	37601
Epididymectomy	37613
Epidural blood patch	18233
catheter, insertion of	39140
electrode, insertion	39130,39139
electrode, management, adjustment etc.	39131
implant, removal of	39136
infusion/injection	(see Group T7)
stimulator, revision of	39133
Epigastric hernia, repair of	30616-30621
Epilation electrolysis, for trichiasis	42587
Epilepsy, operations for	40700-40712
Epiphyseal arrest	48500-48509
plate, prevention of closure	48512
Epiphysiodesis, femur/fibula/tibia	48500,48503,48506
staple arrest of hemi-epiphysis	48509
Epiphysiolysis, to prevent closure of plate	48512
Epispadias, repair of	37836,37839,37842
Epistaxis, treatment of	41656,41677,41680
Epithelial debridement for corneal ulcer/erosion	42650
debridement/eliminating band keratyoplasty	42651
Ergometry, with electrocardiography	11712
Erythrocyte radioactive uptake survival time	12503
screening test, volume Cr51	12500
Escharotomy, decompression, limb or chest	
Ethmoidal artery, transorbital ligation of	41725
sinuses, operation on	41737,41749
Ethmoidectomy, fronto-nasal	41731
fronto-radical	41734
transantral, with radical antrostomy	41713
Eustachian tube, catheterisation of	41755
obliteration of	41564
Evacuation of retained products of conception	16564
Eventration, plication of diaphragm for	43915
Evisceration of globe of eye	42512,42515
Evoked response audiometry, brain stem	11300
responses, central nervous system	11024,11027
Exenteration of orbit of eye	42536
Exomphalos, neonatal, operations for	43870,43873
Exostoses in external auditory meatus, removal	41518
Exostosis, excision of	47933,47936
mandibular or palatal	45825
Exstrophy, cloacal, neonatal, operation for	43882
of bladder, closure	37050
of bladder, repair of	37842
Extensor tendon of hand or wrist, repair of	46420,46423
tendon of hand, tenolysis of	46450
tendon, synovectomy of	46339
External auditory canal, reconstruction	45662,41524
auditory meatus, removal of exostoses	41518
cephalic version	16501
ear, complex total reconstruction of	45660,45661
fixation, orthopaedic, removal	47948,47951
stent, application	34824-34833
External cephalic version	16501
Extra digit, amputation of	46464
Extracardiac conduit, insertion/replacement	38757,38760
Extracorporeal shock wave lithotripsy	36546

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Service	Item
Extracranial to intracranial bypass	39818,39821
Extradural tumour or abscess, laminectomy for	40309
Eye, capsulotomy, laser	42788,42789
carbolisation of	*
coagulation, laser, of corneal/scleral blood vessels	42797
conjunctiva, cautery of	42677
conjunctival graft	42638
corticolysis, laser, of lens material	42791,42792
dermoid, excision of	42573,42574
division of suture, laser	42794
enucleation of	42506,42509,42510
fibrinolysis	42791,42792
foreign body in cornea or sclera, removal of	42644
foreign body in, removal of	42560-42569
foreign body in, superficial, removal of	30061
globe of, evisceration of	42512
investigation of ocular surface dysplasia	11235
iridotomy, laser	42785,42786
iris tumour, laser photocoagulation	42806
orbit, insert/remove implant	42518
paracentesis	42734
phototherapeutic keratectomy, laser	42810
pinguecula, surgical excision	42689
trabeculoplasty, laser	42782
vitreolysis, laser, of lens material	42791
Eyeball, repair of perforating wound	42551,42554,42557
Eyebrow, elevation of	42872
Eyelashes, ingrowing, operation for	45626
Eyelid closure in facial nerve paralysis, implant insertion	42869
composite graft to	45656
ectropion or entropion, correction of	45626
full thickness laceration, repair of	30052
full thickness wedge excision of	45665
grafting for symblepharon	45629
ptosis, correction of	45623
reconstruction of, whole thickness	45614,45671,45674
reduction of	45617,45620
removal of cyst from	42575
tarsorrhaphy	42584
upper recession of	42863

F

Face, repair of complex fractures	45753,45754
chemical peel	45019,45020
Facet joint denervation by percutaneous neurotomy	39118
Facial, nerve, decompression of	41569
nerve palsy, excision of tissue for	45581
nerve paralysis, plastic operation for	45575,45578
scar, revision of (restriction applies)	45506,45512
Facio-hypoglossal/accessory nerve, anastomosis of	39503
Faecal incontinence, sacral nerve stimulation for	32213-32218
Fallopian tubes, catheterisation, with hysteroscopy	35633
tubes, Rubin test for patency	35706
tubes, hydrotubation of	35703,35709
tubes, implantation of, into uterus	35694,35697
tubes, microsurgical anastomosis	35700
tubes, sterilisation	35687,35688
tubes, sterilisation with Caesarean section	35691
Falloposcopy, unilateral/bilateral	35710
Family group psychotherapy	342,344,346
group therapy	170,171,172
Farnsworth Munsell colour discrimination test	*
Fascia, deep, repair of, for herniated muscle	30238
graft	45018
Fasciectomy, for Dupuytren's Contracture	46369-46393
Fasciotomy, forearm or calf	47975,47978,47981
interosseous muscle space of hand	47981
muscle	30226
plantar, radical	49854
subcutaneous, Dupuytren's contracture	46366
Femoral hernia, repair of	30609,30612,30614
vein puncture in infants, blood collection	13312
vessel, ligation/exploration, other	34103
Femoro-femoral crossover bypass grafting	32718
graft, infected, excision of	34172
Femur, bone graft to	48200,48203
congenital deficiency, treatment of	50411,50414
drill decompression of head/neck or both	47982
epiphyseodesis	48500,48506
fracture, treatment of	47516-47537,49336
operation on, for osteomyelitis	43506,43515
osteectomy/osteotomy	48424,48427
Fibreoptic bronchoscopy	41898
colonoscopy	32084-32093
Fibrinolysis	42791,42792
Fibroma, removal of	(see tumour,other)
Fibula, congenital deficiency, transfer fibula to tibia	50423
epiphyseodesis	48503,48506
fracture, treatment of	47576
operation on, for osteomyelitis	43503,43512
osteectomy/osteotomy	48406,48409
Field block	(see nerve)
Filtering and allied operations for glaucoma	42746
Fimbrial cyst, removal of	35712-35717
Finger, amputation of	46465-46483
digital nail, removal of	46513,46516
dislocation, treatment of	47036,47039
flexor tendon sheath, open operation	46522
fracture, treatment of	47300-47333
ingrowing nail, resection of	46528,46531
mallet, fixation/repair	46438,46441
percutaneous tenotomy of	46456
trigger, correction of	46363
Fissure in ano, operation for	32150
Fistula, alimentary, repair of	35596
anal, excision/repair	32159-32166
antrobuccol, operation for	41722
aorto-duodenal, repair of	34160,34163,34166
arteriovenous, dissection, ligation	34112,34115,34118
arteriovenous, dissection, repair	34121-34130
arteriovenous, ligation cervical vessel/s	39812
branchial, removal of	30289
carotid-cavernous, obliteration of	39815
cutaneous, salivary gland, repair of	30269
enterocutaneous, radical resection	30382
genito-urinary, repair	35596
in ano, subcutaneous, excision of	32156
oro-antral, plastic closure of	41722
parotid gland, repair of	30269
sacrococcygeal, excision of	30675,30676
thyroglossal, radical removal of	30314
tracheo-oesophageal, division and repair	43900
urethral, closure of	37833
urethro-rectal	37336
urethro-vaginal	37333
vesical, cutaneous, operation for	37023
vesico-intestinal, closure of	37038

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Service	Item
vesico-vaginal, closure of	37029
wound, review under GA, independent	32168
Fixation, external, removal of	47948,47951
internal, of spine	48678-48690
Flap, Abbe	45701,45704
direct, indirect or local, revision of	45239
free tissue transfer, revision of	45496-45499
indirect	45227-45236
myocutaneous, delay of	45015
myocutaneous, for breast reconstruction	45530
neurovascular island	45563,46504
pharyngeal, for velo-pharyngeal incompetence	45716
repair, direct	45209-45224
repair, local, single stage	45200,45203,45206
repair, muscle, single stage	45000-45012
Flexor tendon, hand, repair of	46426-46435
tendon pulley, reconstruction	46411
tendon sheath, finger or thumb, open operation	46522
tendon, hand, tenolysis of	46453
tendon, hand/wrist, synovectomy of	46339
tendon, wrist, repair of	46426,46429
tendon/s, digit, synovectomy of	46348-46360
Flexorplasty to restore elbow function	50405
Flow volume loops	11512
Fluid Filled Cavity, drainage of	16624
Fluid balance, supervision of	*
Foetal blood sampling	
fluid filled cavity, drainage of	16624
intraperitoneal blood transfusion	
intravascular blood transfusion	
Foeto-amniotic shunt, insertion of	16627
Foot, amputation or disarticulation of	44359,44361,44364
and ankle, tibialis tendon transfer	50339,50342
arthrodesis of	49815,49845
calcaneal spur, excision of	49818
claw or hammer toe, correction of	49848,49851
hallux valgus or hallux rigidus, correction of	49821-49842
metatarso-phalangeal joint, replacement of	49857
metatarso-phalangeal joint, synovectomy of	49860,49863
neurectomy for plantar digital neuritis	49866
paronychia of, pulp space infection, incision	47912
radical plantar fasciotomy or fasciectomy of	49854
tendon of, repair of	49800,49803
tendon or ligament transplantation of	49812
tenotomy of	49806,49809
tibialis tendon transfer	50339,50342
For anaesthesia	20100-25205
Foramen Magnum, tumour or vascular lesion, excision	39662
Forearm, amputation or disarticulation of	44328
decompression fasciotomy of	47975,47978,47981
fracture, treatment of	47378-47393
radial aplasia/dysplasia, centralisation/radialisation	50399
Foreign body, antrum, removal of	41716
bladder, cystoscopic removal of	36833
bronchus, removal of	41895
cornea or sclera, imbedded, removal of	42644
cornea or sclera, superficial, removal of	30061
ear, removal of	41500,41503
implant, contour reconstruction, insertion	45051
intra-ocular, removal of	42560-42569
joint, removal of	(see arthrotomy)
maxillary sinus, removal of	41716
muscle/deep tissue, removal of	30067,30068
nose, removal of	41659
oesophagus, removal of	41825
subcutaneous, removal of	30064
superficial, removal of	30061
tendon, removal of	30067,30068
trachea, removal of	41886
urethra, removal of	37318
Fractures, treatment of	(see body part)
Free grafts	45400-45494
split skin, to burns	45460-45494
transfer of tissue	45563-45565
transfer of tissue, anastomosis artery/vein	45502
Frenulum, mandibular or maxillary, repair	30281
Frontal sinus, catheterisation of	41740
sinus, intranasal operation on	41737
sinus, radical obliteration of	41746
sinus, trephine of	41743
Fronto-ethmoidectomy, radical	41734
Fronto-nasal ethmoidectomy	41731
Fronto-orbital advancement	45782,45785
Full thickness grafts, free	45451
thickness wedge excision of lip, eyelid or ear	45665
Fundi, optic, examination of	11212
Fundoplasty/plication, antireflux operation	30527,30529,30530
antireflux operation by	31464,31466
Funnel chest, elevation of	38457,38458
Furuncle, incision with drainage of	30219,30223
Fusion, spinal, cervical/thoracic/lumbar	48660-48675
spinal, posterior interbody	48654,48657
vertebral body, diseases of	48640

G

Gallbladder, drainage of	30375
excision of	30443-30449
Galvanocautery of skin lesions	30192
Gamete intra-fallopian transfer	13200-13221
Ganglion, excision of	30106,30107
hand, excision of	46494,46495,46498
wrist joint, excision of	46500-46503
Gangliotomy, radiofrequency trigeminal	39109
Gangrenous tissue, debridement of	35100,35103
Gartner duct cyst, removal of	35557
Gastrectomy, partial	30518
sub-total, radical, for carcinoma	30523
total	30521,30524,30526
Gastric by-pass for obesity	30512
band, in association with implanted resevoir	14215,31441
cooling (by lavage with ice-cold water)	*
hypothermia	13500,13503
lavage in the treatment of ingested poison	14200
reconstruction with oesophagectomy	30535
reduction for obesity	30511
stricture, endoscopy with balloon dilatation	30475
tumour, removal of	30520
ulcer, perforated, suture	30375
Gastro-camera investigation	30473
Gastro-oesophageal balloon intubation	13506
reflux, clinical assessment of	11810
reflux, operations for	43951,43954,43957
Gastroduodenal stricture, balloon dilatation	30475
Gastroduodenostomy	30515
reconstruction of	30517
Gastroenterostomy	30515
Gastrointestinal blood loss estimation	12506

*** Payable on attendance basis**

Service	Item
capsule endoscopy, investigation of obscure bleeding	11820
protein loss	12509
tract, dilatation of stricture of upper	41819,41820
Gastroschisis, operations for	43864,43867
Gastroscopy	30473,30476,30478
insertion of nasogastric/nasoenteral tube	31456,31458
Gastrostomy button, non-endoscopic insertion/replacement	30483
gastrosomy	30375
percutaneous endoscopic	30481,30482
percutaneous tube, jejunal extension	31460
Genioplasty	45761
Gilliam's operation	35683,35684
Gland, adrenal, excision of	36500
Bartholin's, marsupialisation of	35516,35517
lacrimal, excision of palpebral lobe	42593
lymph, biopsy of	30074,30075
lymph, drill biopsy of	30078
lymph, pelvic, excision of	35551
lymph, pelvic, excision of, with hysterectomy	35664
parotid, superficial lobectomy/tumour removal	30253
parotid, total extirpation of	30247,30250
salivary, duct, dilatation or diathermy of	30262
salivary, duct, marsupialisation	30265,30266
salivary, duct, meatotomy	30265,30266
salivary, duct, removal of calculus	30265,30266
salivary, operations on	30262-30269
sublingual, extirpation of	30259
submandibular, extirpation of	30256
Glaucoma, filtering and allied operations for	42746,42749
Molteno valve, insertion of	42752
Molteno valve, removal of	42755
iridectomy and sclerectomy for	42746
iridectomy or iridotomy	42764
provocative tests for	11200
tonography for, one or both eyes	11203
Glenoid fossa, reconstruction of	45788
Glioma, craniotomy for removal of	39709
Globe of eye, evisceration of	42512,42515
Glomus tumour, transmastoid removal of	41623
tumour, transtympanic, removal of	41620
Glossectomy, with partial pharyngectomy	41785
Gonadal dysgenesis, vaginoplasty for	37851
Goniotomy	42758
Graciloplasty procedures	32200-32210
Grafenberg's (or Graf) ring, introduction of	35503
ring, removal under GA	35506
Graft, axillo-femoral, infected, excision of	34172
bone	(see bone)
bypass, for occlusive arterial disease	32700-32763
bypass, for treatment of aneurysm	(see aneurysm)
composite (chondro-cutaneous/mucosal)	45656
conjunctival over cornea	42638
corneal	42653,42656,42659
dermis, dermo-fat or fascia	45018
femoro-femoral, infected, excision of	34172
free fascia for facial nerve paralysis	45575,45578
free, split skin	45400-45494
inlay, using a mould	45445
micro-arterial or micro-venous	45503
nerve	39315,39318
skin, to orbit	42524
venous, to fenestration cavity	
Grafting, bypass, occlusive arterial disease	(see bypass)
bypass, treatment of aneurysm	(see aneurysm)
for symblepharon	45629
patch, to artery or vein	33545,33548
Granuloma, cautery of	42677
removal from eye, surgical excision	42689
umbilical, excision under GA	43948
Gravid uterus, evacuation of contents by curettage	35643
Great vessel, intrathoracic operation on, other	38456
vessel, ligation or exploration, other	34103
Greater trochanter, transplant of ileopsoas tendon	50121
Groin, lymph, excision of	30329,30330
Grommet, free, in canal, removal of	*
in situ in drum, removal of	41500
insertion of	41632
Group psychotherapy	342
psychotherapy, family	342,344,346
therapy, family	170,171,172
Gunderson flap operation	42638
Gynaecological examination under GA	35500
Gynatresia, vaginal reconstruction for	35565
H	
Haemangioma, cauterisation of (restriction)	45027
excision of	45030-45036
of neck, deep-seated, excision of	45036
Haemapheresis	13750,13755
Haematoma, aspiration of	30216
breast, exploration and drainage	31551
incision and drainage, without GA	30219
large, incision and drainage, with GA	30223
pelvic, drainage of	30387
Haemochromatosis	13757
Haemodialysis, in hospital	13100,13103
central vein, tunnelled cuffed catheter	34538
removal of tunnelled cuffed catheter	34539
Haemofiltration, continuous (ICU)	13885,13888
in hospital	13100,13103
Haemoperfusion, in hospital	13100,13103
Haemorrhage, antepartum, treatment of	16509
arrest of	*
- following circumcision, with GA	30663
- following circumcision, without GA	*
- following tonsillectomy, with GA	41796,41797
extremity, reoperation for control of	33848
intracranial, burr-hole craniotomy for	39600
nasal, arrest of	41656,41677
nasal, cryotherapy for treatment of	41680
post-op, control under GA, independent	30058
post-operative, following gynaecological surgery	35759
post-operative, laparotomy for	30385
postpartum, treatment of	16567
subdural, tap for	39009
Haemorrhoidectomy	32138,32139
Haemorrhoids, injection into	*
removal of	32138,32139
rubber band ligation of	32135
sclerotherapy for	32132
Hair transplants, congenital/traumatic alopecia	45560
Hallux rigidus/valgus, correction of	49821-49842
Halo, application	47711,47714
femoral traction, application of	47720,47723
thoracic traction, application of	47717
Hammer toe, correction of	49848
Hand, amputation or disarticulation of	44325,44328

*** Payable on attendance basis**

Service	Item
arthrotomy	46327,46330
bone grafting for pseudarthrosis	46405
congenital abnormalities, amputation of phalanges	50396
congenital abnormalities, splitting of phalanges	50396
decompression fasciotomy	47981
digits, flexor/extensor contracture, correction	46492
duplication of digits, amputation of phalanges	50396
duplication of digits, splitting of phalanges	50396
extensor tendon of, repair of	46420,46423
extensor tendon of, tenolysis of	46450
flexor tendon of, repair of	46423-46435
flexor tendon of, tenolysis of	46453
ganglion, excision of	46494
middle palmar/thenar/hypothenar spaces, drainage	46519
osteectomy/osteotomy	46396,46399
paronychia/pulp space infection, incision for	46525
tendon sheath, operation for tendovaginitis	46363
tendon transfer for restoration of function	46417
Hare lip	(see cleft lip)
Harrington rods, in treatment of scoliosis or kyphosis	48609
rods, re-exploration for adjustment /removal	48615
Hartmann's operation	32030
Health assessments	700-706
Care planning	721-731
Case conferencingother than Specialist or Cons Physician	734-779
Case conferencing by Consultant Physician	801-815
Heart arrhythmia, ablation of	38287,38290,38293
arrhythmia, surgery for	38512-38536
catheterisation of	38200,38203,38206
electrical stimulation of	13400
intrathoracic operation on, not otherwise covered	38456
mitral annulus, reconstruction after decalcification	38485
subvalvular structures, reconstruction, re-implantation	38490
surgery for congenital heart disease	38700-38766
surgery, open, not otherwise covered	38653
valve replacement	38488,38489
valve, repair	38480,38481
Heller's operation	30532,30533
Hemiarthroplasty, hand	46309-46321
knee	49517
Hemicircumcision, for hypospadias	37354
Hemicolectomy	32000,32003,32006
Hemiepiphysis, staple arrest of	48509
Hemifacial microsomia, construction condyle and ramus	45791
Hemilaryngectomy, vertical, with tracheostomy	41837
Hemispherectomy, for intractible epilepsy	40706
Hemithyroidectomy	30306
Hemivulvectomy	35536
Hepatic duct, common, resection for carcinoma	30463,30464
duct, common, repair of	30472
ducts, Roux-en-Y bypass	30466,30467
Hepatocellular carcinoma	
destruction by radiofrequency ablation	50950,50952
Hernia, antireflux operations for	30527,30529,30530
diaphragmatic, neonatal, repair of	43837,43840
diaphragmatic, repair of	30600,30601
diaphragmatic, simple closure of	30387
femoral or inguinal, repair of	30609,30612,30614
inguinal, repair, age less than 3 months	44108,44111,44114
spigelian, repair of	30403,30405
strangulated, incarcerated or obstructed, repair of	30615
umbilical, epigastric, or linea alba, repair of	30616-30621
ventral or incisional, repair of	30403,30405
ventral, following closure exomphalos, repair of	43939
Herniated muscle, fascia, deep, repair of	30238
Hiatus hernia, antireflux operations for	30527,30529,30530
hernia, repair of	30601
para-oesophageal, repair of	31468
Hickman catheter, insertion of, for chemotherapy	34527,34528
catheter, removal of	34530
Hindquarter, amputation or disarticulation of	44373
Hinselmann colposcope, examination uterine cervix	35614
Hip, amputation or disarticulation at	44370
arthrectomy	49309,49312
arthrodesis	49306
arthroplasty	49309-49346
arthroplasty, revision	49346
arthroscopy	49360,49363,49366
arthrotomy	49303
congenital dislocation, open reduction	50351
contracture of, medial/anterior release	50375-50384
dislocation, acetabulum fracture, treatment	47495,47498
dislocation, congenital, treatment of	50349,50352
dislocation, treatment of	47048,47051
iliopsoas tendon transfer to greater trochanter	50387
prosthesis, operation on	49315
replacement procedures	49318-49345
spica, application of	47540
spica, initial application, congenital dislocation	50353
transfer of abdominal musculature to greater trochanter	50387
transfer of adductors to ischium	50387
Hirschsprung's disease, colostomy/enterostomy for	30375
disease, neonatal, laparotomy for	43819
disease, paediatric, operations for	43990-43999
Home, dialysis	13104
Hormone implantation, by cannula	14206
implantation, direct, incision and suture	14203
Humerus, bone graft to	48212,48215
fracture, treatment of	47411-47459
operation for osteomyelitis	43506,43515
osteectomy/osteotomy	48412,48415
Hummelsheim type muscle transplant, squint	42848
Hydatid cyst, liver, total excision of	30437,30438
cyst, liver, removal of contents of	30434,30436
cyst, lungs, enucleation of	38424
Hydradenitis, excision for	31245
Hydrocele, infantile, repair of	30612,30614
removal of	30631
tapping of	30628
Hydrocephalus, operations for	40000-40009
Hydrocortisone, injections into keloid with GA	30210
Hydrodilatation of bladder with cystoscopy	36827
Hydromyelia, operations for	40339,40342
Hydrotubation of Fallopian tubes	35703,35709
Hymenectomy	35509
Hyperbaric oxygen therapy	13020,13025,13030
Hyperemesis gravidarum, treatment of	16505
Hyperextension deformity of toe, release, lengthening	50345
Hyperhidrosis, axillary, excision for	30180,30183
botulinum toxin injection, for	18362
Hyperparathyroidism, operations for	30315-30320
Hyperplasia, papillary, of palate, removal of	45831-45835
Hypertelorism, correction, intra/sub-cranial	45767,45770
Hypertension, portal, treatment of	30602-30606
Hyperthermia treatment using Tronado unit	*
Hypertrophied tissue, removal of	45801-45807
Hypnotherapy	*
Hypodermic injections	*

*** Payable on attendance basis**

Service	Item
Hypospadias, examination under GA	37815
granuloplasty, meatal advancement	37818
meatotomy and hemi-circumcision	37354
penis erection test with examination	37815
repair of	37821-37833
urethral fistula repair	37833
Hypothenar spaces of hand, drainage of	46519
Hypothermia, gastric	13500,13503
deep hypothermic circulatory arrest	22075
total body	22065
Hysterectomy	35653-35673
laparoscopically assisted	35750-35756
with ovarian transposition, malignancy	35729
Hysteroscopic resection of myoma or uterine septum	35623,35634
resection of uterine septem	35634
Hysteroscopy	35626-35636
Hysterotomy	35649

I

Ileal atresia, neonatal, laparotomy for	43816
Ileo-femoral by-pass grafting	32712,32718
endarterectomy	33521
Ileorectal anastomosis	32012
Ileostomy	32009-32021
closure of, with rectal resection	32060,32063,32066
closure of, without resection of bowel	30562
refashioning of	30563
reservoir, continent type, creation of	32069
trimming	*
with proctocolectomy	32015
with total colectomy	32009
Iliac endarterectomy	33518
vein, thrombectomy	33810,33811
vessel, ligation or exploration not otherwise covered	34103
Iliopsoas tendon transfer to greater trochanter	50387
Immunisation against infectious disease	*
Implant, cochlear, insertion of	41617
epidural, for pain management, removal of	39136
foreign, insertion for contour reconstruction	45051
insertion or removal from eye socket	42518
Implantation, fallopian tubes into uterus	35694,35697
hormone or living tissue	14203,14206
Implanted, pacemaker testing	11718,11721
device for delivery of therapeutic agents	14221
drug delivery system	39125,39126,39128,39133
loop recorder for investigation of syncope	11722
pump or reservoir, loading of	14218
reservoir associated with adjustable gastric band	14215
Impotence, injection for investigation/treatment	37415
Incidental appendicectomy	30574
Incisional hernia, repair of	30403
Incomplete confinement	16518
Incontinence, anal, Parks' intersphincteric procedure	32126
bladder stress, suprapubic operation	37044
male urinary, injection for treatment of	37339
stress, sling operation for	35599
Indirect flap	45227-45239
Induction, management, second trimester labour	16525
Indwelling oesophageal tube, gastrostomy for fixation	30375
Infantile hydrocele, repair of	30612,30614
Infection, acute intercurrent, complicating pregnancy	16508
Inferior vena cava, thrombectomy	33810,33811
vena caval filter, insertion of	35330
Infiltration, alcohol, etc, around nerve or in muscle	*
of local anaesthetic	(see explan notes)
Inflammation of middle ear, operation for	41626
Infusion chemotherapy	13915-13936
chemotherapy, cannulation for	34521,34524
device, automated, spinal, insertion of	39125-39128
intra-arterial, sympatholytic agent	14209
Ingrowing eyelashes, operation for	45626
nail of finger or thumb, resection of	46528,46531
nail of toe, resection of	47915,47916
Inguinal abscess, incision of	30223
hernia, repair of	30609,30612,30614
hernia, repair, age less than 3 months	44108,44111,44114
Injection, alcohol, etc, around nerve or in muscle	*
alcohol, cortisone, phenol into trigeminal nerve	39100
alcohol, retrobulbar	42824
hormones, for habitual miscarriage	16504
immunoglobulin	*
into angioma (restriction applies)	45027
into joint/synovial cavity	50124,50125
into prostate	37218
into spinal joints or nerves	39013
intramuscular	*
intravenous	*
local anaesthetic	(see explan notes)
sclerosant fluid into pilonidal sinus	30679
Injections, multiple, for skin lesions	30207
varicose veins	*
Inlay graft, using a mould	45445
Innocent bone tumour, excision of	30241
Innominate artery, endarterectomy of	33506
Inoculation against infectious disease	*
Insufflation Fallopian tubes, for patency (Rubin test)	35706
Intensive care management/procedures	13815-13888
Intercostal drain, insertion of	38806,38809
Internal auditory meatus, exploration of	41599
drainage of empyema, without rib resection	38806,38809
Interosseous muscle space of hand, fasciotomy of	47981
Interphalangeal joint, arthrodesis of	46300
joint, arthrotomy of	46327,46330
joint, dislocation, treatment of	47036,47039
joint, hemiarthroplasty	46309-46321
joint, interposition arthroplasty of	46306
joint, joint capsule release of	46381
joint, ligamentous repair	46333
joint, synovectomy/capsulectomy/debridement	46336
joint, total replacement arthroplasty of	46309-46321
joint, volar plate arthroplasty	46307
Interscapulothoracic amputation or disarticulation	44334
Interventional endovascular procedures	35300-35330
Intervertebral disc/s, laminectomy for removal of	40300
disc/s, microsurgical discectomy of	40301
Intestinal conduit or reservoir, endoscopic examination	36860
duct, patent vitello, excision of	43945
malrotation, neonatal, laparotomy for	43801,43804
obstruction, surgical relief of	30387
plication, Noble type, with enterolysis	30375
remnant, abdominal wall vitello, excision of	43942
resection, large	32000,32003
resection, small	30565,30566
sling procedure prior to radiotherapy	32183
urinary conduit, revision	36609
urinary reservoir, continent, formation	36606
Intra-abdominal artery/vein, cannulation, chemotherapy	34521

*** Payable on attendance basis**

Service	Item
malignancy, radical or debulking operation	30392
Intra-anal abscess, drainage of	32174,32175
Intra-aortic balloon, counterpulsation, management	13848,13847
balloon pump, insertion of	38609,38362
balloon pump, removal of	38612,38613
Intra-arterial cannulisation for blood collection	13842
infusion chemotherapy	13927-13936
infusion, of sympatholytic agent	14209
Intra-atrial baffle, insertion of	38745
Intra-epithelial neoplasia, laser therapy for	35539,35542,35545
Intra-ocular excision of dermoid of eye	42574
foreign body, removal of	42560-42569
procedures, resuturing of wound after	42857
Intra-operative ultrasound, biliary tract	30439
staging of intra-abdominal tumours	30441
Intra-oral tumour, radical excision of	30275
Intra-orbital abscess, drainage of	42572
Intracerebral tumour, craniotomy and removal of	39709
Intracranial abscess, excision of	39903
aneurysm, clipping or reinforcement of sac	39800
aneurysm, ligation of cervical vessel/s	39812
arteriovenous malformation, excision of	39803
cyst, drainage of via burr-hole	39703
electrode placement	40709,40712
haemorrhage, burr-hole craniotomy for	39600,39603
infection, drainage of via burr-hole	39900
neurectomy, for trigeminal neuralgia	39106
pressure monitoring device, insertion of	39015
pressure monitoring, catheter/subarachnoid bolt	13830
stereotactic procedures	40800,40803
tumour, biopsy and/or decompression	39706
tumour, burr-hole biopsy for	39703,39706
tumour, craniotomy and removal of	39709,39712
Intradiscal injection of chymopapain	40336
Intradural lesion, laminectomy for, not otherwise covered	40312
Intrahepatic bypass	30466,30467
Intramedullary tumour, laminectomy and radical excision	40318
Intramuscular injections	*
Intranasal operation on antrum/removal offoreign body	41716
operation on frontal sinus or ethmoid sinuses	41737
operation on sphenoidal sinus	41752
Intrascleral ball or cartilage, insertion of	42515
Intrathecal infusion device, revision of	39133
infusion/injection	(see Group T7)
steroid injection	18232
Intrathoracic operation on heart, lungs, etc, other	38456
vessels, anastomosis/repair	38727,38730
Intrauterine contraceptive device, introduction of	35503
contraceptive device, removal of under GA	35506
device, introduction of, for idiopathic menorrhagia	35502
growth retardation, attendance for	16508
Intravascular injections	*
brachytherapy, for coronary artery restenoses	15360,15363,15541
pressure monitoring	13876
Intravenous infusion chemotherapy	13915-13924
injections	*
perfusion of a sympatholytic agent	14209
regional anaesthesia of limb	18213
Intraventricular baffle, insertion of	38754
Intubation, small bowel	30487,30488
Intussusception, reduction of	30375
management fluid/gas reduction for	14212
paediatric, operations for	43933,43936
Invitro fertilisation	13200-13221
processing of bone marrow	13760
Ionisation, cervix	35608
corneal ulcer	*
zinc, of nostrils, in the treatment of hay fever	*
Iontophoresis, collection of specimen of sweat by	12200
Iridectomy	42764
and sclerectomy, for glaucoma (Lagrange's op)	42746
following intraocular procedures	42857
Iridencleisis	42746
Iridocyclectomy	42767
Iridotomy	42764
laser	42785,42786
Iris and ciliary body, excision of tumour of	42767
excision of tumour of	42764
tumour, laser photocoagulation of	42806
Iron kinetic test	12503
Ischaemic limb, debridement of deep tissue	35100
limb, debridement of superficial tissue	35103
ventricular septal rupture, repair of	38509
Ischio-rectal abscess, drainage of	32174,32175
abscess, incision with drainage	30223
insertion of, for drainage of middle ear	41632
intravascular brachytherapy for the treatment of coronary artery restenoses	15360,15363,15541,38321,38324,38327,38330

J

Jacket, plaster, application of, to spine	47708
Jaw, dislocation, treatment of	47000
aspiration biopsy of cyst/s	45799
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512,45815
reconstruction operation	45596-45611
Jejunal atresia, bowel resection and anastomosis	43810
extension, percutaneous gastrostomy tube	31460
Jejunostomy, operative feeding	31462
Joint, application of external fixator, not for fracture	50130
arthrodesis of	50109
arthroplasty of, not otherwise covered	50127
arthroscopy of	50100
arthrotomy of	50103
aspiration of (restriction applies)	50124,50125
cicatricial flexion contracture of, correction	50112
deformity, correction of	50300
dislocation, treatment of	47024-47045
finger/hand, debridement of	46336
greater trochanter, transplantation of	50121
injection into	50124,50125
manipulation of	50115
sacro-iliac, arthrodesis	49300
sacro-iliac, disruption of	47513
stabilisation, repair capsule/ligament	50106
subtalar, arthrodesis of	50118
synovectomy of, not otherwise covered	50104
Juvenile cataract, removal of	42716

K

Keloid, excision of	(see tumour,other)
extensive, multiple injections of hydrocortisone	30210
Keratectomy, partial, for corneal scars	42647
phototherapeutic	42810
Keratocanthoma, removal of	31255-31295
Keratoplasty	42653,42656,42659

*** Payable on attendance basis**

Service	Item
Keratosis, obturans, surgical removal	41509
treatment of	*
Kidney, dialysis, in hospital	13100,13103
donor, continuous perfusion of	22055
exploration of	36537
ruptured, exposure and exploration of	36576
solitary, pyeloplasty by open exposure	36567
transplant	36503,36506,36509
Kirschner wire, insertion of	47921
Klockoff's test, assessment of cochlear function changes	11321
Knee, amputation at or below	44367
arthrodesis of	49512,49545
arthroplasty of	49518-49534
arthroscopy of	49557-49566
arthrotomy of	49500
collateral or cruciate ligament repair	49503,49506
congenital deformity, post-op manipulation, plaster	50348
contracture of, posterior release	50363-50372
cruciate ligament reconstruction	49536,49539,49542
dislocation, treatment of	47054
fracture, treatment of	47588,47591
hamstring tendon transfer	50357,50360
hemiarthroplasty of	49517
ligament or tendon transfer	49503,49506
meniscectomy of	49503,49506
mobilisation, for post-traumatic stiffness	49569
nerve block for control of post op pain	18210,18211
orthopaedic treatment of	49503,49506
patello-femoral stabilisation	49503,49506,49564
patello-femoral stabilisation, revision of	49548
prosthesis, removal of	49515
reconstruction/repair	49536,49539
rectus femoris tendon transfer	50357
replacement procedures	49518-49534
revision of orthopaedic procedures	49551,49554
synovectomy of	49509
Kyphosis, spinal fusion for	48606,48609,48613

L

Labial adhesions, separation of	*
Labioplasty, where medically indicated	35533
Labour, second trimester, management of	16525
Labyrinth, destruction of	41572
Labyrinthotomy	41572
Labyrinths, caloric test of	11333,11336
Laceration, ear/eyelid/nose/lip, full thickness, repair	30052
repair and suturing of	30026-30049
Lacrimal canalicular system, establishment patency	42599,42602
canaliculus, immediate repair of	42605
drainage by insertion of glass tube	42608
gland, excision of palpebral lobe	42593
passages, obstruction, probing for	42610-42615
sac, excision of	42596
Lagrange's operation (iridectomy and sclerectomy)	42746
Laminectomy and insertion of epidural implant	39139
followed by posterior fusion	40324,40327
for cordotomy or myelotomy	39124
for extradural tumour or abscess	40309
for hydromelia	40342
for intradural lesion	40312
for recurrent disc lesion and/or spinal stenosis	40303
for removal of intervertebral disc/s	40300
for spinal stenosis	40303,40306
with bone graft and posterior fusion	48654,48657
with excision of arteriovenous malformation	40318
with excision of intra-medullary tumour	40318
Laparascopic division of adhesions	31450,31452,35637
splenectomy	31470
Laparoscopy and hysteroscopy under GA	35636
complicated operative	35638,35641
diagnostic	30390
division of adhesions	30393,35637
involving procedures via laparoscope	35637,35638
laparoscopically assisted hysterectomy	35750-35756
on abdominal viscera	30375
sterilisation via	35687,35688
with biopsy	30391
with drainage of pus	31454
with transection/resection Fallopian tubes	35687,35688
Laparostomy	30397,30399
Laparotomy and division of adhesions	30376,30378,30379
exploratory	30373
for control of post-operative haemorrhage	30385,33845
for drainage	30394
for grading of lymphoma	30384
for gross intra-peritoneal sepsis	30396
for intussusception, paediatric	43933,43936
for neonatal conditions	43801-43831
for staging of gynaecological malignancy	35726
for thrombosis	33845
for trauma, involving 3 or more organs	30388
involving gynaecology (exc. hysterectomy)	35712-35717
on abdominal viscera	30375,30387
with division of extensive adhesions	30379
with insertion of portacath	30400
Large intestine, resection of	32000,32003
intestine, subtotal colectomy	32004,32005
Laryngeal web, division of	41868
Laryngectomy	41834
supraglottic	41840
Laryngofissure, external operation on	41876
Laryngopharyngectomy	41843
- or primary restoration of alimentary continuity after	41843
- with tracheostomy and plastic reconstruction	30294
Laryngoplasty	41876,41879
Laryngoscopy	41846,41849,41852
fibreoptic, with examination of larynx	41764
Larynx, direct examination of	41846
direct examination of, with biopsy	41849
direct examination of, with removal of tumour	41852
external operation on	41876
fibreoptic examination of	41764
fractured, operation for	41873
Laser: ablation of prostate, endoscopic	37207,37208
Doppler interferometry of eyes	11240-11243
angioplasty, peripheral	35315
capsulotomy	42788,42789
coagulation corneal/scleral vessels	42797
destruction of bladder tumour with cystoscopy	36845,36840
destruction of stone with urethroscopy	37318
diathermy/visual laser for lesion of prostate	37224-37224
division of suture, eye	42794
excision, tumours of face/neck	30190
incision of palate	41787
iridotomy	42785,42786
photocoagulation of iris tumour	42806
photocoagulation of neoplastic skin lesions	30195

*** Payable on attendance basis**

Service	Item
photocoagulation of vascular lesions	14100-14124
photoiridosyneresis	42808
photomydriasis	42807
removal of cancer of skin/mucous membrane	30196
removal of palmar/plantar warts	30187
resurfacing, carbon dioxide, face or neck	45025,45026
therapy for intraepithelial neoplasia	35539,35542,35545
therapy for malignancy of gastrointestinal tract	30479
trabeculoplasty	42782,42783
treatment, eye	42782-42806
vitreolysis/corticolysis	42791,42792
Lateral pharyngeal bands, removal of	41804
pharyngotomy	41779
rhinotomy with removal of tumour	41728
Lavage and proof puncture of maxillary antrum	41698,41701
colonic, total, intra-operative	32186
colostomy	*
gastric, in the treatment of ingested poison	14200
maxillary antrum	41704
stomach	*
uterine (saline flushing)	*
Le Fort osteotomies	45753,45754
operation for genital prolapse	35578
Leg, amputation	44367,44370
hamstring tendon transfer	50357,50360
rectus femoris tendon transfer	50357
Lens, artificial, insertion of	42701,42703
artificial, removal and replacement	42707,42710
artificial, removal or repositioning	42704
extraction	42698
extraction and insertion of artificial lens	42702
intraocular, repositioning of	42713
Lensectomy	42731
Lesion, craniocervical junction, transoral approach for	40315
intradural, laminectomy for, not otherwise covered	40312
Lesions, skin, multiple injections for	30207
Leukoplakia, tongue, diathermy for	*
Leveen shunt, insertion of	30408
Lid, ophthalmic, suturing of	42584
scleral graft to	42860
Ligament, finger joint, repair of	46333
of foot, repair of	49812
or tendon transfer	47966
ruptured medial palpebral, repair of	42854
transplantation	47966
Ligation, great vessel	34103
purse string, cervix	16511
rubber band, of haemorrhoids or rectal prolapse	32135
transantral, of maxillary artery	41707
Ligature of cervix, purse string, removal of	16512
Limb, fasciotomy of	30226
Limb, amputation	(see leg/arm)
ischaemic, debridement of tissue	35100,35103
lengthening procedures	50303,50306
lower, congenital deficiency, treatment of	50411,50414,50417
or chest, decompression escharotomy	45054
perfusion of	34533,22055
Limbic tumour, removal or excision of	42692,42695
Linea alba hernia, repair of, under 10 years	30616,30617
alba hernia, repair of, over 10 years	30620,30621
Lingual tonsil, removal of	41804
Lip, cleft, operations for	45677-45704
full thickness laceration, repair	30052
full thickness wedge excision	45665
reconstruction	45671,45674
tumour, excision of	(see tumour,other)
Lipectomy, radical abdominoplasty	30177
subumbilical excision	30174
wedge excision	30165,30168,30171
Lipoma, removal of	(see tumour, other)
Lipomeningocoele, tethered cord, release of	40112
Liposuction, for post-traumatic pseudolipoma	45584,45585
abdominal contouring post diabetic injections	31346
for reduction of a buffalo hump	45586
free tissue transfer, complete revision of	45497
free tissue transfer, first stage revision of	45498
free tissue transfer, second stage revision	45499
Lippe's loop, introduction of	35503
loop, removal of under GA	35506
Lisfranc's amputation	44364
Litholapaxy, with or without cystoscopy	36863
Lithotripsy, extracorporeal shock wave (ESWL)	36546
Little's Area, cautery of	41674
Liver abscess, open abdominal drainage of	30431,30433
biopsy	30409,30411,30412
cyst/s, laparoscopic marsupialisation	30416,30417
hydatid cyst, removal of contents of	30434,30436
hydatid cyst, total excision of	30437,30438
lobectomy of, for trauma	30428,30430
lobectomy of, other than for trauma	30418,30421
repair of laceration/s, for trauma	30422,30425
ruptured, repair	30375
segmental resection of	30414,30415,30427
tumours destruction by radiofrequency ablation	50950,50952
tumours, destruction of by cryotherapy	30419
Living tissue, implantation of	14203,14206
Lobar emphysema, neonatal, thoracotomy & lung resection	43861
Lobectomy, liver, for trauma	30428,30430
liver, other than for trauma	30418,30421
lung	38438,38441
partial, for epilepsy	40703
superficial, of parotid gland	30253
Local anaesthetic, injection of	(see explan notes)
flap repair	45200,45203,45206
flap revision	45239
infiltration, nerve/muscle, with alcohol etc.	*
Loose bodies in joint	(see arthrotomy)
Lop ear or similar deformity, correction of	45659
Lord's procedure, massive dilatation of anus	32153
Lumbar cerebrospinal fluid drain, insertion of	40018
decompression of spinal cord	40351
discectomy, percutaneous	48636
puncture	39000
shunt diversion, insertion of	40006
shunt, revision or removal of	40009
sympathectomy	35000,35009
Lunate bone, osteectomy or osteotomy of	48406
Lung compliance, estimation of	11503
hydatid cysts, enucleation of	38424
intrathoracic operation, not otherwise covered	38456
needle biopsy of	38812
resection, congenital cystadenomatoid malformation	43861
resection, congenital lobar emphysema	43861
volumes	11503
wedge resection of	38440
Lymph glands, axilla, excision of	30332,30335,30336
glands, biopsy of	30074,30075,30078
glands, groin, excision of	30329,30330

*** Payable on attendance basis**

Service	Item
glands, pelvic, radical excision of	35551
node biopsies, retroperitoneal	35723
node dissection, retroperitoneal	37607,37610
node of neck, biopsy of	31420
nodes of axilla, excision of	30335,30336
nodes of neck, dissection of	31423-31438
sentinel node biopsy for breast cancer	30299-30303
Lymphadenectomy, atypical mycobacterial infection	44130
granulomatous disease	44130
pelvic	35551,36502
Lymphangiectasis, limbs, major excision	45048
Lymphangioma, excision of	45030-45036
Lymphoedema, major excision of	45048
Lymphoid patches, removal of	45801-45809
M	
Macrocheilia, operation for	45675
Macrodactyly, surgical reduction of enlarged elements	46510
Macroglossia, operation for	45675
Macrostomia, operation for	45676
Macules, electrosurgical destruction or chemotherapy of	*
Magnetic removal of intraocular foreign body	42560,42566
Malignant lesion, removal of	31300-31335
Malignant upper aerodigestive tract tumour excision of	31400,31403,31406
Mallet finger, closed pin fixation of	46438
finger, open repair of text test	46441
finger, with intra-articular fracture, open reduction	46442
Mammaplasty, augmentation	45524,45527,45528
reduction	45520,45522
Mammary prosthesis, removal of	45548,45551,45552
prosthesis, replacement of	45552,45554
Manchester operation for genital prolapse	35577
Mandible, condylectomy	45611
dislocations, treatment of	47000
hemi-mandibular reconstruction with bone graft	45608
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512,45815
or maxilla, fractures, treatment of	47753-47789
osteectomy or osteotomy of	45720-45752
resection of	45599,45602,45605
segmental resection of, for tumours	45605
Mandibular, frenulum, repair of, under GA	30281
or palatal exostosis, excision of	45825
Manipulation of fibrous tissue surrounding breast prosthesis	*
of joints	50115
of spine	48600,48603
of ureteric calculus, endoscopic	36857
without anaesthesia	*
Manometric oesophageal motility test	11800
Manometry, biliary	30493
Marshall-Marchetti operation for urethropexy	35599,37044
Marsupialisation of Bartholin's cyst or gland	35516,35517
salivary gland	30265,30266
Mastectomy, total	31518,31521
subcutaneous	31524,31527
Mastitis, granulomatous, exploration and drainage	31551
Mastoid cavity, obliteration of	41548,41564
portion, decompression of facial nerve	41569
Mastoidectomy, cortical	41545
intact wall technique, with myringoplasty	41551,41554
radical or modified radical	41557-41564
revision of, with myringoplasty	41566
with insertion of cochlear implant	41617
with transmastoid removal of glomus tumour	41623
Maxilla, operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512,45815
or mandible, fractures, treatment of	47753-47789
osteectomy or osteotomy	45720-45752
resection of, segmental, for tumour/cyst	45605
resection of, sub-total	45602
resection of, total	45596,45597
Maxillary antrum, lavage of	41704
antrum, proof puncture and lavage of	41698,41701
artery, transantral ligation of	41707
frenulum, repair of	30281
sinus lift procedure	45849
sinus, drainage of, through tooth socket	41719
sinus, operations on	41710-41722
tuberosity, reduction of	45829
Meatoplasty, with correction of auditory canal stenosis	41521
with removal of cartilage and/or bone	41512,41515
Meatotomy and hemi-circumcision, hypospadias	37354
ureteric, with cystoscopy	30265,30266,36830
urethral	37321
Meatus, external auditory, removal of exostoses in	41518
external auditory, removal of keratosis obturans	41509
internal auditory, exploration of	41599
pinhole urinary, dilatation of	37300
Meckel's diverticulum, removal of	30375
Meconium ileus, laparotomy for	43813,43816
Medial palpebral ligament, ruptured, repair of	42854
Median bar, endoscopic resection of	36854
sternotomy for post-operative bleeding	38656
Mediastinum, cervical exploration of	38448
exploration of, for hyperparathyroidism	30318,30320
intrathoracic operation on, not otherwise covered	38456
Meibomian cyst, extirpation of	42575
Melanoma, removal of	31300-31335
excision of, oral & maxillofacial region	45801-45809
Melasma, full face chemical peel	45019,45020
Meloplasty, for correction of facial asymmetry	45587,45588
Membranes, retained, evacuation of	16564
Meningeal haemorrhage, operations for	39600,39603
Meningocele, excision and closure of	40100
Meniscectomy, knee	49503,49506
temporo-mandibular	45755
Mesenteric artery, inferior, operation on	32736
vessels, by-pass grafting to	32730,32733
Meso caval shunt for portal hypertension	30603
Metacarpal bones, amputation of	44325
bones, bone grafting, pseudarthrosis	46402,46405
bones, fracture, treatment of	47336-47345
bones, operation for osteomyelitis	46462
bones, osteotomy/osteectomy	46396,46399
Metacarpophalangeal joint, arthrodesis	46300
joint, arthroplasty	46306-46321
joint, arthrotomy	46327,46330
joint, dislocation, treatment of	47042,47045
joint, hemiarthroplasty	46309-46321
joint, ligamentous repair of	46333
joint, volar plate arthroplasty	46307
Metacarpus, operation on, for chronic osteomyelitis	43512
Metastatic carcinoma, craniotomy for removal of	39709
Metatarsal bones, osteotomy or osteectomy of	48400,48403
fracture, treatment of	47633-47657
Metatarso-phalangeal joint, synovectomy of	49860,49863

*** Payable on attendance basis**

Service	Item
joint, total replacement of	49857
Metatarsus, amputation or disarticulation of	44358
operation on, for acute osteomyelitis	43500
Micro-arterial graft	45503
Microdochotomy of breast, benign or malignant condition	31554
Microlaryngoscopy	41855
- with arytenoidectomy	41867
- with division of laryngeal web	41868
- with removal of juvenile papillomata	41858
- with removal of papillomata by laser surgery	41861
- with removal of tumour	41864
Microsomia, construction of condyle and ramus	45791
Microvascular anastomosis using microsurgical techniques	45502
repair using microsurgical techniques	45500,45501,45504
Microvenous graft	45503
Middle ear, clearance of	41635,41638
ear, exploration of	41629
ear, insertion of tube for drainage of	41632
ear, operation for abscess or inflammation of	41626
palmar spaces of hand, drainage of	46519
Midtarsal amputation of foot	44364
Miles' operation	32039
Minitracheostomy insertion	41884
Minnesota tube, insertion of	13506
Miscarriage, habitual, treatment of	16504
incomplete, curettage for	35639,35640
threatened, ligation of cervix	16511
threatened, treatment of	16505
Mitral annulus, reconstruction after decalcification	38485
valve, open valvotomy of	38487
Mitrofanoff continent valve, formation of	37045
Moh's procedure	31000,31001,31002
Mole, desiccation by diathermy	*
retained, evacuation of	16564
Molluscum contagiosum, removal in operating theatre	30189
Morbid obesity, operations for	30511,30512,30514
Moschowitz operation	35590
Motility test, manometric, of oesophagus	11800
Mouth, premalignant growth in, removal of	(see tumour,other)
Mucous membrane, biopsy of	30071
membrane, cancer, treatment	30196-30205
membrane, graft	42641
membrane, repair of recent wound	30026-30049
Multiple delivery, administration of anaesthetic	
Multiple, injections for varicose veins	32500,32501
pregnancy, interventional techniques	16633,16636
Muscle, activity sampling (electromyography)	11012,11015,11018
biopsy of	30074,30075
distal, devascularisation of	32200
excision of	30226,30229
excision of, with melanoma	31340
extra-ocular, ruptured, repair of	42854
flap repair	45000,45009,45012
flap, delay of	45015
local infiltration in	*
removal of foreign body from	30067,30068
ruptured, repair of	30232,30235
transfer for facial nerve paralysis	45578
transplant (Hummelsheim type), for squint	42848
Myelomeningocele, excision and closure of	40103
Myelotomy, laminectomy for	39124
Mylohyloid ridge, reduction of	45827
Myocardial electrode, permanent, insertion, thoracotomy	38470
biopsy, by cardiac catherterisation	38275
Myocutaneous flap, delay of	45015
flap repair	45003,45006
Myoma, hysteroscopic resection	35623
Myomectomy, hypertrophic obstructive cardiomyopathy	38650
uterine, abdominal	35649
uterine, laparoscopic	35638
Myotomy, cricopharyngeal	41770,41776
hypertrophic obstructive cardiomyopathy	38650
ocular muscles	42833,42839,42851
oesophagogastric (Heller's operation)	30532,30533
Myringoplasty	41527,41530
- and mastoidectomy	41551,41560
- and ossicular chain reconstruction	41542
- and revision of mastoidectomy	41566
- with mastoidectomy and ossicular chain recon	41554,41563
Myringotomy	41626

N

Service	Item
Naevus, excision of	31250
excision of, in oral & maxillofacial region	45801-45809
Nail bed, exploration and repair of deformity	46489
bed, reconstruction of laceration	46486
digital, of finger or thumb, removal of	46513,46516
digital, of toe, removal of	47904,47906
ingrowing, of finger or thumb, resection	46528,46531
ingrowing, of toe, excision/resection	47915,47916,47918
ingrown, of toe, operation under GA, paediatric	44136
plate injury/deformity, radical excision	46534
plate or rod, removal of	47930
Narcotherapy	*
Nasal adhesions, division of	41683
bones, fracture, treatment of	47735,47738,47741
cavity and/or post nasal space, examination of	41653
cavity, packing for arrest of haemorrhage	41677
haemorrhage, arrest of	41656,41677
haemorrhage, cryotherapy in the treatment of	41680
polyp or polypi, removal of	41662,41665,41668
septum button, insertion of	41907
septum, reconstruction of	41672
septum, septoplasty or submucous resection	41671
space, post, direct examination of	41761
turbinates, cryotherapy	41695
Nasendoscopy	41764
Naso-lacrimal tube, replacement of	42610-42615
Nasopharyngeal angiofibroma, transpalatal removal	41767
Nasopharynx, fibreoptic examination of	41764
Neck, deep-seated haemangioma, excision of	45036
excision of infected by-pass graft	34157
scar, revision of (restriction applies)	45506,45512
Necrosectomy, pancreatic	30577
Necrotic material, debridement of	35100,35103
Needle biopsy, aspiration	*
biopsy of prostate	37218
biopsy of vertebra	30093
Needling of cataract	42734
needling of encysted bleb	42744
Neonatal alimentary obstruction, laparotomy for	43825
surgery	43801-43822
Neoplasia, intraepithelial, laser therapy	35539,35542,35545
Neoplastic lesions, cutaneous, treatment of	30195
Nephrectomy	36516-36529
radical, for nephroblastoma, paediatric	43984
Nephro-ureterectomy, complete, with bladder repair	36531

*** Payable on attendance basis**

Service	Item
for tumour	36532
for tumour, complicated	36533
Nephroblastoma, operations for	43981,43984
Nephrolithotomy	36540,36543
Nephroscopy	36627-36648
Nephrostomy	36552
drainage tube, exchange of, imaging guided	36649
percutaneous, using interventional imaging	36624
Nerve Block	(see Nerve)
separate examination in preparation for	17603
Nerve block, regional or field	18206-18298
conduction studies	11012,11015,11018
cranial, intracranial decompression	39112
cutaneous, nerve graft to	39318
cutaneous, repair of	39300,39303
exploration of	39330
facio-hypoglossal or facio-accessory, anastomosis of	39503
graft to nerve trunk	39315
intracranial, for trigeminal neuralgia	39106
local infiltration around, with alcohol etc	*
peripheral, removal of tumour from	39324,39327
sacral, stimulation for faecal incontinence	32213-32218
section, retrolabyrinthine, vestibular/cochlear	41596
section, translabyrinthine, vestibular	41593
stimulation for pain	39130-39139
transposition of	39321
trigeminal, primary branch, injection with alcohol etc	39100
trunk, internal (interfasicular), neurolysis of	39312
trunk, microsurgical repair	39306,39309
trunk, nerve graft to	39315
vestibular, section of, via posterior fossa	39500
Neurectomy, foot, for plantar digital neuritis	49866
intracranial, for trigeminal neuralgia	39106
peripheral nerve	39324,39327
transantral vidian, with antrostomy	41713
Neuroblastoma, operations for	43981,43984,43987
Neuroendocrine tumour, retroperitoneal, removal of	30321,30323
Neuroendoscopy	40903
Neurolysis, by open operation	39330
of nerve trunk	39312
Neuroma, acoustic, removal of	41575-41579
Neuromuscular electrodiagnosis	11012-11021
Neurostimulator receiver, spinal, subcutaneous placement	39134
Neurotomy, of peripheral nerves	39327
percutaneous, for facet joint denervation	39118
percutaneous, of spinal nerves	39115
Neurovascular island flap, for pulp innervation	46504
island flap, with vascular pedicle	45563
Nipple, accessory, excision of	31566
inverted, surgical eversion of	31563
reconstruction of	45545,45546
Noble type intestinal plication with enterolysis	30375
Node, lymph, biopsy of	30074,30075
scalene, biopsy	30096
Nodes, lymph, pelvic, excision of	35551
Nodule, treatment, electrosurgical destruction/cryosurgery	*
Non-gravid uterus, suction curettage of	35639,35640
Nose, cauterisation or packing, for haemorrhage	41677
composite graft to	45656
cryotherapy to, for haemorrhage	41680
dermoid of, congenital, excision of	41729
foreign body in, removal of, other than simple	41659
fracture, treatment of	47735,47738,47741
full thickness repair of laceration (restriction)	30052
operations, other	41659-41695
plastic operations	45632-45653

O

Obesity, morbid, surgical reversal of gastric procedure	30514
Ocular muscle, torn, repair of	42854
coherence biometry/tomography	11240-11243
surface dysplasia, investigation	11235
transillumuination	42821
Oculoplethysmography, carotid vessels	11618,11621,11624
Odontoid screw fixation	40316
Oesophageal atresia, neonatal, operations for	43843-43858
atresia/corrosive stricture, replacement for	43903
motility test, manometric	11800
perforation, repair of, by thoracotomy	30560
prosthesis, insertion of	30490
stricture, endoscopic dilatation of	41819,41820
transection for portal hypertension	30606
tube, indwelling, gastrostomy for fixation	30375
Oesophagectomy	30535-30557
cervical	30294
Oesophagogastric myotomy	30532,30533
Oesophagoscopy	30473-30478
with dilatation of stricture	41819,41820
with rigid oesophagoscope	41816,41822,41825
Oesophagostomy, cervical	30293,30294
cervical, neonatal oesophageal atresia	43858
closure or plastic repair of	30293
Oesophagus, resection of stricture, paediatric	43906
balloon dilatation of	41832
dilatation of	41819-41831
intrathoracic operation on, not otherwise covered	38456
local excision for tumour	30559
removal of foreign body in	41825
Olecranon, excision of bursa of	30110,30111
fracture, treatment of	47396,47399,47402
Omentectomy, infra-colic	35726
with debulking operation	35720
Oophorectomy, laparoscopic	35638
with laparotomy, not with hysterectomy	35712-35717
with vaginal hysterectomy	35673
Open heart surgery, not otherwise covered	38653
Operative arteriography or venography	35200
cholangiography or pancreatography	30439
feeding jejunostomy	31462
laparoscopy, complicated	35641
Ophthalmological examination under GA	42503
Optic fundi, examination of	11212
nerve meninges, incision of	42548
Optical coherence biometry/tomography	11240-11243
Orbit, anophthalmic, insertion of cartilage or implant	42518
anophthalmic, placement of motility integrating peg	42518
eye, decompression of	42545
eye, exenteration of	42536
eye, exploration of	42530,42533
eye, removal tumour/foreign body	42539,42542,42543
eye, skin graft to	42524
Orbital cavity, bone or cartilage graft to	45593
cavity, reconstruction of	45590
contents, partial coherence interferometry of	11240-11243
contents, ultrasonic echography of	11240,11241,11242,11243
dermoid, congenital, excision of	42574
dystopia, correction of	45776,45779

*** Payable on attendance basis**

Service	Item
implant, enucleation of eye	42506,42509
implant, evisceration of eye and insertion of	42515
Orbitotomy	42530,42533
Orchidectomy	30638,30641
Orchidopexy for undescended testis	37803,37806,37809
Oro-antral fistula, plastic closure of	41722
pin or wire, insertion of	47921
Oro-nasal fistula, plastic closure of	45714
Orthopaedic pin or wire, insertion of	47921
ring fixator, adjustment of	50309
Osseo-integration procedures	45794,45797,45847
Ossicular chain reconstruction	41539,41542
Osteectomy of accessory bone	48400
carpus	48406,48409
clavicle	48406,48409
femur	48424,48427
fibula	48406,48409
humerus	48412,48415
mandible or maxilla	45720-45752
metatarsal	48400,48403
pelvic bone	48424
pelvis	48427
phalanx	48400,48403
radius	48406
rib	48406
scapula (other than acromion)	48406
sesamoid bone	48400
tarsus	48406
tibia	48418,48421
ulna	48406
Osteomyelitis, acute or chronic, operations for	43500-43524
carpus, operation for	46462
metacarpal, operation for	46462
operations for, in oral and maxillofacial region	45815,45817
phalanx, operation for	46459,46462
skull, craniectomy for	39906
Osteoplasty of knee	49503,49506
Osteotomy of accessory bone	48400
carpus	48406,48409
clavicle	48406,48409
femur	48424,48427
fibula	48406,48409
foot	49833-49838
humerus	48412,48415
mandible or maxilla	45720-45752
metatarsal	48400,48403
midfacial	45753,45754
pelvic bone	48424
pelvis	48427
phalanx	48400,48403
radius	48406,48409
rib	48406,48409
scapula (other than acromion)	48406,48409
sesamoid bone	48400
tarsus	48406,48409
tibia	48418,48421
ulna	48406,48409
Otitis media, acute, operation for	41626
Oto-acoustic emission audiometry	11332
Oval window surgery	41615
Ovarian biopsy by laparoscopy	35637
cyst aspiration	35518
cyst, excision of, with hysterectomy	35673
cyst, excision of, with laparotomy	35712-35717
cyst, puncture of, via laparoscope	35637
cystectomy, laparoscopic	35638
transposition with hysterectomy for malignancy	35729
tumour, radical or debulking operation for	35720
Ovaries, prolapse, operation for	30387
Oxycephaly, cranial vault reconstruction for	45785
Oxygen consumption, estimation of	11503
therapy, hyperbaric	13020,13025,13030
ovaries, operation for	30387-30387
rectum, abdominal rectopexy	32117
rectum, perineal repair of	32120
rectum, reduction of	*
rectum, rubber band ligation of	32135
rectum, sclerotherapy for	32132
urethra	35570,35573
urethra, excision of	37369
vaginal, repair of	35568-35597

P

Pacemaker electrode, permanent, insertion, sub-xyphoid	38473
gracilis neosphincter	32210
implanted, testing of	11718,11721
permanent, insertion or replacement	38353
Pacemaking electrode, temporary transvenous, insertion	38256
Pain management, implanted drug delivery system	39125-39133
spinal and peripheral nerve stimulation	39130-39139
Palatal exostosis, excision of	45825
Palate, cleft, repair of	45707,45710,45713
papillary hyperplasia removal of	52609-52615
Palmar warts, removal of	30186,30187,30185
Palpebral ligament, medial, ruptured, repair of	42854
lobe of lacrimal gland, excision of	42593
Pancreas, drainage of	30375
excision of	30583
Pancreatectomy	30583,30593,30594
Pancreatic abscess, laparotomy and external drainage of	30575
cyst, anastomosis to Roux loop of jejunum	30587
cyst, anastomosis to stomach or duodenum	30586
juice, collection of	30488
necrosectomy	30577
Pancreatico-duodenectomy (Whipple's operation)	30584
Pancreatico-jejunostomy	30589,30590
Pancreato-cholangiography, endoscopic	30484
Pancreatography, operative	30439
Panendoscopy	30473,30476,30478
Panhysterectomy	35664
Pannus, treatment of, with cautery of conjunctiva	42677
Papilloma, bladder, transurethral resection	36845,36840
larynx, removal of	41852
removal in oral & maxillofacial region	45801-45809
removal of	(see tumour,other)
Papillomata, juvenile, removal with microlaryngoscopy	41858
removal of by laser surgery	41861
Papules, electrosurgical destruction or chemotherapy of	*
Para-oesophageal, hiatus hernia, repair of	31468
Paracentesis abdominis	30406
anterior or posterior chamber or both	42740
in relation to eye	42734
of pericardium	38406
of tympanum	41626
thoracic cavity	38803
Paralysis, facial nerve, plastic operations for	45575,45578
Parapharyngeal tumour, excision of	31409,31412

*** Payable on attendance basis**

Service	Item
Paraphimosis, reduction of under GA	30666
Parathyroid operation for hyperparathyroidism	30315
Parental nutrition	
central vein, tunnelled cuffed catheter	34538
removal of tunnelled cuffed catheter	34539
Paretic states, eyebrows, elevation of	42872
Parks' intersphincteric operation	32126
Paronychia of foot, incision for	47912
of hand, incision for	46525
Parotid duct, diathermy or dilatation	30262
duct, meatotomy or marsupialisation	30265,30266
duct, removal of calculus	30265,30266
duct, repair of,	30246
fistula, repair of	30269
gland, superficial lobectomy/removal of tumour	30253
gland, total extirpation of	30247,30250
tumour, excision of	30251
Parovarian cyst, removal of	35712-35717
Partial coherence interferometry of eyes	11240-11243
Patch angioplasty for vein stenosis	34815
grafting to artery or vein	33545,33548
testing, epicutaneous	12012-12021
Patella, bursa, excision of	30110,30111
congenital dislocation, reconstruction of quadriceps	50420
dislocation, treatment of	47057,47060
fracture, treatment of	47579,47582,47585
Patellar bursa, excision of	30110,30111
Patellectomy	49503,49506
Patello-femoral stabilisation	49503,49506,49564
stabilisation, revision of	49548
Patent diseased coronary bypass vein graft, dissection	38637
ductus arteriosus, division/ligation	38700,38703
urachus, excision of	37800
Pectus carinatum, repair or radical correction	38457
excavatum, repair or radical correction	38457,38458
Pedicle, tubed, or indirect flap	45230
- delay of	
- formation of	45227
- preparation of site and attachment to site	45233
- spreading of pedicle	45236
Pelvi-ureteric junction, plastic procedures to	36564
cystoscopy of	36825
Pelvic abscess, drainage via rectum or vagina	30223
abscess, laparotomy for drainage of	30394
bone, operation on, for osteomyelitis	43509,43518
bone, osteectomy or osteotomy of	48424,48427
floor abnormalities, diagnosis of	11830,11833
floor repair, laparoscopic or abdominal	35595
haematoma, drainage of	30387
lymph glands, excision of	35551,35664,35670
ring, fracture, treatment of	47474-47489
Pelvic lymphadenectomy	36502
Pelvis, bone graft/shelf procedure, acetabular dysplasia	50393
fracture, treatment of	47474-47510
osteotomy or osteectomy of	48424,48427
Penicillin, injection of	*
Penile warts, cystoscopy for treatment of	36815
Penis, amputation of	37402,37405
artificial erection device, insertion	37426,37429
artificial erection device, revision or removal of	37432
circumcision of	30653-30660
correction of chordee	37417,37418
frenuloplasty	37435
injection for impotence	37415
lengthening by translocation of corpora	37423
paraphimosis, reduction of under GA	30666
partial amputation of	37402
repair of avulsion	37411
repair of laceration of cavernous tissue, or fracture	37408
surgery for penile drainage causing impotence	37420
Peptic ulcer, bleeding, control of	30505-30509
ulcer, perforated, suture of	30375
Per anal release, rectal stricture	32114
Perchlorate discharge study	12521
Percutaneous aspiration biopsy of deep organ	30094
biliary dilatation	30495
biliary drainage	30440,30451,30495
biliary stenting	30492
cordotomy	39121
drainage of deep abscess, imaging guided	30224
endoscopic gastrostomy	30481,30482
epidural electrode, insertion	39130
epidural electrodes, management of	39131
epidural implant, removal	39136
gastrostomy tube, jejunal extension	31460
liver biopsy	30409
lumbar discectomy	48636
needle biopsy of lung	38812
neurotomy for facet joint denervation	39118
neurotomy of peripheral nerves	39323
neurotomy of spinal nerves	39115
retrieval of foreign body	35360-35363
retrieval of inferior vena caval filter	35331
transhepatic cholangiogram, imaging guided	30440
ureteric stent exchange	36608
Perforated duodenal ulcer, suture of	30375
gastric ulcer, suture of	30375
peptic ulcer, suture of	30375
Perforating wound of eyeball, repair of	42551,42554,42557
Perfusion of donor kidney, continuous	22055
of limb or organ	22055
retrograde, cerebral (if performed)	22075
retrograde, intravenous, sympatholytic agent	14209
whole body	22060
Perianal abscess, drainage of	32174,32175
abscess, incision with drainage	30223
excision of rectal tumour	32103,32104,32106
tag, removal of, without GA	*
thrombosis, incision of	32147
Pericardectomy	38447,38449
Pericardium, drainage of, sub-xyphoid	38452
drainage of, transthoracic	38450
paracentesis of	38406
Perimetry, quantitative	*
quantitative, computerised	11221-11225
Perineal anoplasty, ano-rectal malformation	43960
biopsy of prostate	37212
graciloplasty	32203,32209
graciloplasty, insert. stimulator & electrode	32209
prostatectomy	37200
recto-sigmoidectomy for rectal prolapse	32112
repair of rectocele	32131
repair, rectal prolapse	32120
stimulation maximal, electrical	*
stimulation maximal, for stress incontinence	*
Perineorrhaphy	35571
and anterior colporrhaphy	35580
Perinephric abscess, drainage of	36537

*** Payable on attendance basis**

Service	Item
area, exploration of	36537
Periorbital correction of Treacher Collins Syndrome	45773
Doppler examination, carotid vessels	11618,11621,11624
dermoid, congenital, excision of	42573
Peripheral arterial atherectomy	35312
arterial catheterisation	35321
cannulation for cardiopulmonary bypass	38603
laser angioplasty	35315
nerve, neurectomy/neurotomy/tumour	39324,39327
peripheral nerve stimulation for pain	39131-39137
venous catheterisation	35317,35319,35320
vessels, examination of	11603-11612
Peritomy, conjunctival	42632
Peritoneal adhesions, division, with laparotomy	30376,30378,30379
biopsies, multiple, with infracolic omentectomy	35726
catheter, insertion and fixation of	13109
catheter, removal of	13110
dialysis	13112
Peritoneo venous (Leveen) shunt, insertion of	30408
Peritoneoscopy	(see laparoscopy)
Peritonitis, laparotomy for	30394
Peritonsillar abscess, incision of	41807
Periurethral injection for urinary incontinence	37339
Perthes, hips or knees, application of cast under GA	50390
Petro-clival and clival tumour, removal of	39653,39654,39656
Peyronie's plaque, operation for	37417
Phalanges, amputation/splitting, congenital abnormalities	50396
Phalanx, bone grafting of, for pseudarthrosis	46402,46405
distal, for osteomyelitis	46459
finger or thumb, fractures, treatment of	47300-47333
middle or proximal, for osteomyelitis	46462
operation for acute osteomyelitis	43500
operation for chronic osteomyelitis	43512
osteectomy or osteotomy of	46399,48400,48403
toe, fracture, treatment of	47663-47678
Pharyngeal adhesions, division of	41758
bands or lingual tonsils, removal of	41804
cysts, removal of	41813
flap for velo-pharyngeal incompetence	45716
pouch, endoscopic resection (Dohlman's op)	41773
pouch, removal of	41770
Pharyngectomy, partial	41782,41785
Pharyngoplasty	45716
Pharyngotomy (lateral)	41779
Pharynx, cauterisation or diathermy	41674
removal of foreign body from	30061
Phlebotomy	*
Phonoangiography, carotid vessels	11618,11621,11624
Phonocardiography	11706
Photocoagulation, laser, vascular lesions	14100-14124
of xenon arc	42782,42783
Photoiridosyneresis, laser	42808
Photomydriasis, laser	42807
Phototherapeutic, keratectomy	42810
Physician, consultant, attendance by	(see attendances)
Pigeon chest, correction of	38457
Pilonidal cyst or sinus, excision of	30675,30676
sinus, injection of sclerosant fluid	30679
Pin, orthopaedic, insertion of	47921
wire or screw, buried, removal of	47924,47927
Pinealoma, craniotomy for removal of	39712
Pinguecula, removal of	42689
Pinhole urinary meatus, dilatation of	37300
Pirogoff's amputation of foot	44361
Pitanguy abdominoplasty	30177
Pituitary tumour, removal of	39715
Placement of catheters	38220,38222,38243
Placement of catheters and injection of opaque material	
Placenta, retained, evacuation of	16564
ultrasonic localisation by Doppler	*
Placentography, preparation for	36800
Plantar fasciotomy, radical	49854
warts, removal of	30186,30187
Plaster jacket, application of, to spine	47708
Plastic procedures to pelvi-ureteric junction	36564
reconstruction for bicornuate uterus	35680
reconstruction of lacrimal canaliculus	42602
repair, direct flap	45209-45224
repair, of cervical oesophagostomy	30293
repair, single stage, local flap	45200,45203,45206
repair, to enlarge vaginal orifice	35569
Plate, rod or nail, removal of	47930
Plethysmography	11604-11612
Pleura, percutaneous biopsy of	30090
Pleural effusion	38803
Pleurectomy with thoracotomy	38424
Pleurodesis with thoracotomy	38424
Plexus, brachial, exploration of	39333
Plication, intestinal, with enterolysis, Noble type	30375
Pneumonectomy	38438,38441
Poison, ingested, gastric-lavage in the treatment of	14200
Polycythemia	13757
Polyhydramnios, attendance, not routine antenatal	16502
Polyp, anal, excision of	32142,32145
aural, removal of	41506,41509
cervix, removal of	35611
larynx, removal of	41852
nasal, removal of	41662,41665,41668
rectal, removal with sigmoidoscopy	32078,32081
uterus, removal of	35639,35640
Polypectomy, with hysteroscopy	35633
Popliteal artery, exploration of, for popliteal entrapment	34145
vessel, ligation or exploration, other	34103
Porta hepatitis, radical resection for carcinoma	30461
Portacath, laparatomy with insertion of	30400
Portal hypertension, operations for	30602-30606
Porto caval shunt for portal hypertension	30602
Portoenterostomy for biliary atresia	43978
Posterior chamber, removal of silicone oil	42815
sclerotomy	42734
spinal fusion	40321,40324,40327
vaginal compartment repair	35571,35573
Postero-lateral bone graft to spine	48648,48651
Postnasal space, examination under GA	41653
space, direct examination with/without biopsy	41761
Postnatal care	16564-16573
Postoperative haemorrhage	30058
- control under GA, independent	30058
- laparotomy for control of	30385
- tonsils/adenoids, arrest, under GA	41796,41797
following gynaecological surgery, under GA	35759
pain, control of	18206-18212
Postpartum haemorrhage, treatment of	16567
Pre-auricular sinus, excision of	30104
Preeclampsia, treatment of	16509
Pregnancy, attendance for complication by	16508
- acute intercurrent infection	
- diabetes or anaemia	16502

*** Payable on attendance basis**

Service	Item
- intrauterine growth retardation	16508
- threatened premature labour	16502,16508
multiple, attendance other than routine antenatal	16502
Premalignant skin lesions, treatment of	30192
Premature labour, attendances not routine antenatal	16502,16508
Preoperative examination for anaesthesia	17603
Prepuce, breakdown of adhesions of	*
operations on	30653-30666
Presacral and sacrococcygeal tumour, excision of	32036
sympathectomy	35012
Pressure monitoring, intracranial	13830
monitoring, intravascular	13876
Priapism, decompression of	37393
shunt operation for	37396
Primary repair of cutaneous nerve	39300
repair of extensor tendon of hand or wrist	46420
repair of flexor tendon of hand or wrist	46426,46432
repair of nerve trunk	39306
restoration of alimentary continuity	41843
Proctectomy, perineal	32047
Proctocolectomy with ileostomy	32015,32018,32021
Proctoscopy	*
Products of conception, retained, evacuation of	16564
Professional attendances	(see attendance)
Profilometry, urethral pressure	11906,11909
Progesterone implant	14203,14206
Prolonged professional attendance, lifesaving	160-164
Proof puncture of maxillary antrum	41698,41701
Prostate, biopsy of	37212-37219
diathermy or visual laser destruction of	37224-37224
endoscopic laser ablation	37207,37208
total excision of	37209,37210,37211
transurethral radio-frequency needle ablation	37201,37202
Prostatectomy, endoscopic	37203,37206
open	37200
radical	37210,37211
Prostatic abscess, endoscopic drainage of	37221
abscess, open drainage of	37212
coil, insertion of	37223
Prosthesis, breast, manipulation fibrous tissue surrounding	*
breast, removal and/or replacement	45548-45555
knee, removal of	49515
oesophageal, insertion of	30490
shoulder, removal of	48927
Provocative test for glaucoma	11200
Pseudarthrosis, bone grafting of metatarsal for	46402,46405
bone grafting of phalanx for	46402,46405
Psychiatry, by consultant psychiatrists	(see attendances)
Psychotherapy, by consultant psychiatrists	(see attendances)
Pterygium, removal of	42686
Ptosis of eyelid, correction of	45623,45624,45625
breast, correction of (unilateral)	45556,45557
Public health physicians - attendances	410-417
Pudendal and spinal nerve motor latency, measurement	11833
Pulmonary artery, banding of	38715,38718
artery catheterisation	13818
artery pressure monitoring, open heart	11627
-under 12 years of age	
decortication with thoracotomy	38421
Pulp space infection of foot, incision for	47912
space infection of hand, incision for	46525
Pulse generator, subcutaneous placement	39134
Pump or resevoir, loading of	14218
implanted, associated with adjustable gastric band	31441
Punch biopsy of synovial membrane	30087
Punctum, occlusion of	42620,42621,42622
snip operation	42617
Purse string ligation, cervix	16511
string ligature of cervix, removal	16512
Puva therapy	14050,14053
Pyelography retrograde, preparation for	36824
Pyelolithotomy	36540,36543
Pyeloplasty, by open exposure	36564,36567,36570
Pyeloscopy, retrograde	36652,36654,36656
Pyelostomy, open	36552
Pyloromyotomy for pyloric stenosis	43930
Pyloroplasty	30375
reconstruction of	30517
Pylorus, dilation of, with vagotomy	30502
Pyogenic granulation, cauterisation of	*
Pyonephrosis, drainage of	36537

Q

Quadriceps, patella, reconstruction, congenital dislocation	50420
Quadricepsplasty, for knee mobilisation	49569
Quinsy, incision of	41807

R

Radial vessel, ligation or exploration, other	34106
Radiation dosimetry	15518-15536
field setting	15500-15515
oncology treatment	15203-15214
proctitis, anorectal application of formalin	32212
Radioactive B12 absorption test	12512,12515
Radiofrequency ablation	
destruction/non-resectable liver cancer	50950,50952
Radioisotope, therapeutic dose, administration of	16003-16012
Radiosurgery, stereotactic	15600
Radiotherapy, deep or orthovoltage	15100-15115
planning	15500-15536
radioactive sources, sealed	15303-15357
radioactive sources, unsealed	16003-16018
superficial	15000-15012
Radioulnar joint, dislocation, treatment of	47024,47027
joint, distal, reconstruction/stabilisation	46345
joint, distal, synovectomy	46342
Radius, bone graft to	48218-48227
fracture, treatment of	47360-47408
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
osteectomy or osteotomy of	48406,48409
Ranula, removal of	30282,30283
Rectal biopsy, full thickness	32096
fistula, closure of	37038,37336
polyp, removal of with sigmoidoscopy	32078,32081
prolapse, Delorme procedure for	32111
prolapse, abdominal rectopexy of	32117
prolapse, paediatric, injection under GA	44105
prolapse, perineal recto-sigmoidectomy for	32112
prolapse, perineal repair of	32120
prolapse, reduction of	*
prolapse, rubber band ligation of	32135
prolapse, sclerotherapy for	32132
stricture, dilatation of	32115
stricture, per anal release of	32114
tumour, excision of	32099,32102,32108,32103,32104,32106

*** Payable on attendance basis**

Service	Item
Rectocele, perineal repair of	32131
vaginal compartment repair of	35571
Rectopexy, abdominal, of rectal prolapse	32117
Rectosigmoidectomy (Hartmann's operation)	32030
perineal, for rectal prolapse	32112
Rectosphincteric reflex, measurement of	11830
Rectovaginal fistula, repair of	35596
Rectum and anus, abdomino-perineal resection of	32039-32046
anterior resection of	32024-32028
examination under GA, paediatric	44102
perineal resection of	32047
suction biopsy of	30071
Recurrent hernia, repair of	30403
Reduction mammaplasty (unilateral)	45520
with surgical repositioning of nipple	45520
without surgical repositioning of nipple	45522
Reduction ureteroplasty	36618
Refitting of contact lenses	10816
Reflux, gastro-oesophageal, correction	43951,43954,43957
vesico-ureteric, correction	36588
Regional nerve block	(see nerve)
Regitine phentolamine test for phaeochromocytoma	*
Renal artery, aberrant, operation for	36537
biopsy (closed)	36561
cyst, excision of	36558
dialysis in hospital	13100,13103
function test	12524,12527
pelvis, brush biopsy of, with cystoscopy	36821
transplant	36503,36506,36509
Resevoir, implanted associated with gastric band	14215,31441
or pump, loading of	14218
Respiratory function, estimation of	11503-11512
Resuturing of wound following intraocular procedures	42857
Retina, cryotherapy of	42728,42818
detached, diathermy or cryotherapy for	42773
detached, removal of encircling silicone band	42812
detached, resection or buckling operation for	42776
detached, revision operation for	42779
light coagulation for	42782,42783
photocoagulation of	42809
pre-detachment of, cryotherapy for	42818
Retinal photography	11215,11218
Retrobulbar abscess, operation for	42572
injection of alcohol	42824
Retrolabyrinthine vestibular nerve section	41596
Retroperitoneal abscess, drainage of	30402
lymph node biopsies	35723
lymph node dissection	37607,37610
neuroendocrine tumour, removal of	30321,30323
Retropharyngeal abscess, incision with drainage	30223
Retropubic prostatectomy	37200
Retroversion, operation for	35683,35684
Rhinophyma, carbon dioxide laser ablation/excision	45652
shaving of	45653
Rhinoplasty procedures	45632-45644
secondary revision of	45650
Rhinotomy, lateral, with removal of tumour	41728
Rhizolysis, spinal	40330
Rib, cervical, removal of	34139
first, resection of portion	34136
fracture, treatment of	47471
operation for acute osteomyelitis	43503
operation for chronic osteomyelitis	43512
osteectomy or osteotomy of	48406,48409
resection, with radical operation for empyema	38415
Ring fixator, adjustment of	50309
Rod, plate or nail, removal of	47930
Rodent ulcer, operation for	(see ulcer,other)
Rosen incision, myringoplasty	41527
Rotational atherectomy, of the coronary artery	38309-38318
Rotator cuff of shoulder, repair of	48906,48909
Round window repair or cochleotomy	41614
Roux-en-Y biliary bypass	30460,30466,30467
Rovsing's operation	36537
Rubin test for patency of Fallopian tubes	35706
Ruptured medial palpebral ligament, repair of	42854
membranes, threatened premature labour	16508
muscle, repair of	30232,30235
thoracic aorta, operative management of	38572
urethra, repair of	37306,37309
viscus, simple repair of	30375

S

Sacral sinus, excision of	30675,30676
colpopexy	35597
nerve stimulation for faecal incontinence	32213-32218
sympathectomy	35012
Sacro-iliac joint, arthrodesis of	49300
joint disruption, treatment of	47513
Sacrococcygeal and presacral tumour, excision of	32036
teratoma, neonatal, excision of	43876,43879
Salivary gland, major, transposition of duct	41910
gland, operations on	30262-30269
Salpingectomy, laparoscopic	35638
with laparotomy, not with hysterectomy	35712-35717
with vaginal hysterectomy	35673
Salpingo-oophorectomy not with hysterectomy	35712-35717
Salpingolysis	35694,35697
Salpingostomy	35694,35697
laparoscopic	35638
Saphenous vein anastomosis	34809
Scalene node biopsy	30096
Scalenotomy	34133
Scalp vein catheterisation in a neonate	13300
Scaphoid, bone graft to	48230,48233,48236
Scapula, fracture, treatment of	47468
(other than acromion), osteectomy/osteotomy	48406,48409
operation for chronic osteomyelitis	43512
Scar, abrasive therapy to	45021,45024
face or neck, revision of (restriction applies)	45506,45512
in oral and maxillofacial region	45801-45807
other than face or neck, revision of (restriction)	45515,45518
other, removal of	31200-31240
Scars, corneal, removal of, by partial keratectomy	42647
Schilling test	12512,12515
Sclera, removal of imbedded foreign body	42644
removal of superficial foreign body	30061
transplantation of	42662,42665
Scleral blood vessels, laser coagulations of	42797
graft to lid	42860
Sclerectomy and iridectomy for glaucoma	42746
Sclerosant fluid, injection of into pilonidal sinus	30679
injection of starburst vessels, head/neck	30213,30214
injection of telangiectases, head/neck	30213,30214
Scoliosis, anterior correction of (Dwyer procedure)	48621,48624
application of halo	47714
congenital, vertebral resection and fusion for	48632

*** Payable on attendance basis**

Service	Item
re-exploration for	48615
requiring anterior decompression of spinal cord	48630
revision of failed surgery	48618
spinal fusion for	48606-48613
spinal fusion for, with segmental instrumentation	48627
spinal fusion with use of Harrington rod	48681
Screw, pin or wire, buried, removal of	47924,47927
Scrotal contents, exploration of	37604
Scrotum, excision of abscess of	30223
partial excision of	37438
Sebaceous cyst, removal of	(see cyst,other)
Second trimester labour, management of	16525
Secondary, repair of extensor tendon of hand or wrist	46423
repair of flexor tendon of hand or wrist	46429
Segmentectomy	38438
Selective coronary angiography	38215-38246
Semen, collection of	13290,13292
Semimembranosus bursa, excision of	30114
Seminal vesicle/ampulla of vas, total excision of	37209
Sengstaken-Blakemore tube, insertion of	13506
Sentinel lymph node biopsy for breast cancer	30299-30303
Septal defect, atrial, closure of	38742
defect, ventricular, closure of	38751
perforation, closure of	41671
Septectomy, cardiac	38739,38748
Septoplasty of nasal septum	41671
Septostomy, or balloon valvuloplasty	38270
Septum button, nasal, insertion of	41907
nasal, cauterisation/diathermy	41674
nasal, reconstruction of	41672
nasal, septoplasty or submucous resection	41671
vaginal, excision of, for correction of double vagina	35566
Sequestrectomy	43512-43524
Seroma, breast, exploration, drainage, operating theatre	31551
Sesamoid bone, osteotomy or osteectomy of	48400
Seton, readjustment of, in anal fistula	32166
Shirodkar suture	16511
Shoulder, amputation or disarticulation at	44331
Stabilisation procedure for recurrent anterior or posterior dislocation	48930
arthrectomy or arthrodesis	48939,48942
arthroscopic surgery	48948-48960
arthroscopy	48945
arthrotomy	48912
dislocation, treatment of	47009,47012,47015
hemi-arthroplasty of	48915
nerve block for post op pain	18212
open reduction for congenital dislocation	50408
orthopaedic treatment of	48900,48903
prosthesis, removal of	48927
removal of calcium deposit from cuff	48900
rotator cuff, repair of	48906,48909
spica, application of	47540
stabilisation, for multidirection instability	48933
synovectomy of	48936
total replacement of	48918,48921,48924
Shunt, aorto-pulmonary or cavo-pulmonary	38733,38736
arteriovenous, external, insertion/removal	34500,34506
cranial or cisternal, insertion of	40003
cranial or cisternal, revision or removal of	40009
lumbar, insertion of	40006
lumbar, revision or removal of	40009
Sigmoidoscopic examination	32072,32075
- with diathermy or resection of polyp/s	32078,32081
Sigmoidoscopy, fibreoptic, flexible	32084,32087
Silicone band, encircling, removal from detached retina	42812
breast prosthesis, removal of	45555
Sinoscopy	41764
Sinus, diathermy of	*
ethmoidal, external operation on	41749
excision of	30099,30102,30103
frontal, catheterisation of	41740
frontal, radical obliteration of	41746
frontal, trephine of	41743
injection of sclerosant fluid under anaesthesia	30679
intranasal operation on	41737
maxillary, drainage of, through tooth socket	41719
pilonidal, excision of	30675,30676
pre-auricular, excision of	30104
sphenoidal, intranasal operation on	41752
urogenital, vaginal reconstruction for	35565
Skin, biopsy of	30071
cancer, treatment of	30196-30205
full face chemical peel	45019,45020
graft to orbit	42524
grafts	(see graft)
lesions, multiple injections for	30207
lesions, treatment of	30192,30195
malignant lesion, removal of	31300-31335
repair of recent wound of	30026-30049
sensitivity testing for allergens	12000,12003
subcutaneous tissue, extensive excision	31245
tags, anal, excision of	32142,32145
Skull base surgery for tumour removal	39640-39662
base tumour, removal, infra-temporal	41581
calipers, insertion of	47705
fracture, attendance for treatment of	47703
fractured, operations for	39606-39615
osteomyelitis, acute, operation for	43503
osteomyelitis, chronic, operation for	43521
osteomyelitis, craniectomy for	39906
treatment of fracture, not requiring operation	47703
tumour, excision of	39700
Sleep apnoea, overnight investigation for	12203,12207
Overnight paediatric investigation	12215,12210,12213,12217
Sling operation for stress incontinence	35599
procedure, intestinal, prior to radiotherapy	32183
Slough, debridement of	35100,35103
Small bone, exostosis, excision of	47933
bowel intubation	30487,30488
bowel strictureplasty	30564
bowel, endoscopic examination of	32095
intestine, resection of	30565,30566
Small bowel, capsule endoscopy, investigation of obscure bleeding	11820
Smith's fracture of radius, treatment of	47369,47372,47375
Smith-Petersen nail, removal of	47924,47927
Socket, eye, contracted, reconstruction of	42527
Specialist attendance	(see attendance)
Specimen of sweat, collection of, by iontophoresis	12200
Speech discrimination tests	11321
Spermatic cord, exploration of, inguinal approach	30644
Spermatocele, excision of	37601
Sphenoidal sinus, intranasal operation on	41752
Sphincter, anal, direct repair of	32129
anal, stretching of	32153
bladder, endoscopic incision/resection	36854
muscle and pelvic floor abnormalities, diagnosis of	11833

*** Payable on attendance basis**

Service	Item
of Oddi, transduodenal operation on	30458
urethral, reconstruction	37375
urinary, artificial, insertion	37381,37384,37387
urinary, artificial, revision or removal	37390
Sphincterotomy, anal, independent procedure	43999
endoscopic	30485,36854
Spinal and pudendal nerve motor latency, measurement	11833
catheter, insertion of for infusion device	39125,39128
cord, cervical decompression	40331-40335
fusion to cervical, thoracic or lumbar regions	48660-48675
fusion, application of halo for scoliosis	47714
fusion, posterior	40321,40324,40327
fusion, posterior interbody, with laminectomy	48654,48657
nerves, injection into	39013
nerves, percutaneous neurotomy	39115
neurostimulator receiver, subcutaneous placement	39134
rhizolysis	40330
shunt for hydrocephalus	40006
spinal stimulation, for pain	39131-39139
stenosis, laminectomy for	40303,40306
thoracic decompression	40345,40348
thoraco-lumbar/high lumbar decompression	40351
using segmental instrumentation	48613
Spine, application of plaster jacket to	47708
bone graft to	48642-48651
fracture, treatment of	47681-47702
internal fixation of	48678-48690
manipulation of	48600,48603
operation on, for acute osteomyelitis	43509
operation on, for chronic osteomyelitis	43518
Spirometry	11506,11509
Spleen, ruptured, repair of	30375
Splenectomy	30597,30599
laparoscopic	31470
Spleno renal shunt, selective, for portal hypertension	30605
Splenorrhaphy	30596
Split skin free grafts, granulating areas	45400,45403
skin free grafts to one defect	45439-45448
Sports physcians, attendances by medical practitioners who are sports phsyicians	444-449
Squamous cell carcinoma, removal of	31255-31295
Squint, muscle transplant (Hummelsheim type)	42848
operation for	42833-42842
readjustment of adjustable sutures	42845
recurrent, operation for	42851
Staging laparotomy for gynaecological malignancy	35726
Stapedectomy	41608
Stapes mobilisation	41611
Staple arrest of hemi-epiphysis	48509
Starburst vessels, head/neck, diathermy or injection	30213,30214
Stenosing tendovaginitis, hand/wrist, open operation	46363
Stenosis, arteriovenous fistula/access device, correction of	34518
auditory canal, correction of	41521
spinal, laminectomy for	40303,40306
tracheal, dilatation of, with bronchoscopy	41904
venous, operations for	34812,34815
Stent, external, application restore valve competency	34824-34833
insertion, transluminal	35306,35309,35307
insertion, transluminal, rotational atherectomy	38312,38318
ureteric, passage through nephrostomy tube	36604
Stereotactic procedures	40800,40801,40803
radiosurgery	
Sterilisation (female)	35687,35688
in conjunction with Caesarean section	35691
Sternal wire/s, removal of	38460
Sternocleidomastoid muscle, bipolar release, torticollis	50402
Sternotomy for removal of thymus or mediastinal tumour	38446
involving division of adhesions	38643,38647
median, for post-operative bleeding	38656
wound, debridement of	38462,38464
Sternum and mediastinum, reoperation for infection	38468,38469
biopsy of	30081,30084,30087
fracture, treatment of	47466,47467
operation for acute osteomyelitis	43503
operation for chronic osteomyelitis	43512
reoperation for dehiscence or infection	38466
Stomach lavage	*
lavage in the treatment of ingested poison	14200
Stone/s, biliary/renal tract, extraction of	(see calculus)
removal of, by urethroscopy	36540,36543
Strabismus, operation for	42833-42839
botulinum toxin injection, for	18362
operation for	
Stress incontinence, abdomino-vaginal operation	35602,35605
treatment by maximal perineal stimulation	*
Marshall-Marchetti, urethropexy	35599,37044
Stamey or similar type needle colposuspension	37043
sling operation	35599,37042
suprapubic procedure for	37044
Stricture, anal, anoplasty for	32123
oesophagus, dilatation of	41819
rectal, dilatation of	32115
rectum, plastic operation to	30387
tracheal, dilatation of, with bronchoscopy	41904
urethral, dilatation of	37303
Strictureplasty, small bowel	30564
Strontium 89, administration of	16015
Stump, amputation, reamputation of	44376
amputation, trimming of	*
cervix-residual, removal of, abdominal approach	35612
cervix-residual, removal of, vaginal approach	35613
Styloid process of temporal bone, removal of	30244
Sub-valvular structures, heart, reconstruction, re-implant	38490
Subclavian artery, endarterectomy	33506
to femoral bypass grafting	32715
vessel, ligation/exploration, other	34103
Subcutaneous fasciotomy, Dupuytren's contracture	46366
fistula in ano, excision of	32156
foreign body, removal not otherwise covered	30064
tenotomy	47960
tissue, repair of recent wound of	30026-30049
Subdural haemorrhage, tap for	39009
Sublingual gland, duct, removal of calculus	30265,30266
gland, extirpation of	30259
gland, meatotomy or marsupialisation	30265,30266
Submandibular abscess, incision of	30223
ducts, relocation of	30255
gland, extirpation of	30256
Submaxillary gland, repair of cutaneous fistula	30269
Submucous resection of nasal septum	41671
resection of turbinates	41692
Subperiosteal abscess	43500-43524
Subphrenic abscess, laparotomy for drainage of	30394
Subtalar arthrodesis	50118
Subtemporal decompression	40015
Subungual haematoma, incision of	30219
Suction biopsy of rectum	30071
curettage of uterus	35639,35640,35643

*** Payable on attendance basis**

Service	Item
Supraglottic laryngectomy with tracheostomy	41840
Suprapubic cystostomy or cystotomy	37008
cystostomy tube, change of	*
prostatectomy	37200
stab cystotomy	37011
Surgical reduction of enlarged elements, macrodactyly	46510
wounds, resuturing of (not burst abdomen)	*
Suspension of uterus	35683,35684
Suture, laser division of, eye, following trabeculoplasty	42794
shirodkar	16511
traumatic wounds	30026-30049
Sutures, adjustable, readjustment of, for squint	42845
dressing and removal of, requiring GA	30055
Swann-Ganz catheterisation	13818
Sweat, collection of specimen of, by iontophoresis	12200
gland bearing area, excision of	30180,30183
Sycosis barbae/nuchae, excision of	31245
Symblepharon, grafting for	45629
Syme's amputation of foot	44361
Sympathectomy, chemical	(see nerve blocks)
surgical	35000-35012
Symphysis pubis, fracture, treatment of	47474-47489
Syndactyly, repair	(see flap repair)
Synechiae, division of	42761
Synovectomy, of ankle	50312
of elbow	49109
of finger joints	46336
of hand tendons	46336,46342
of joint, not otherwise covered	50104
of metatarso-phalangeal joint	49860,49863
of shoulder	48936
of tendons of digit	46348-46360
total, of knee	49509
total, of wrist	49224
Synovial cavity, aspiration of	50124,50125
membrane, punch biopsy of	30087
sacrospinous colpopexy	35568

T

Talipes equinovarus, cast/manipulation/splint	49878
equinovarus, procedures for	50315-50330
Talus fracture, treatment of	47606-47618
vertical, congenital, reconstruction	50336
Tantalum markers, surgical insertion of	42805
Tarsal cartilage, excision of	42578
cauterisation of, for ectropion or entropion	42581
coalition, excision of	50333
cyst, extirpation of	42575
Tarsometatarsal joint, fracture, treatment of	47621,47624
joint, Lisfranc's amputation of	44364
Tarsorrhaphy	42584
Tarsus, dislocation, treatment of	47063,47066
fracture, treatment of	47627,47630
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
osteectomy or osteotomy of	48406,48409
Tear duct, probing of	42610-42615
third degree, repair of	16573
Teflon injection, into vocal cord	41870
injection, peri-urethral	37339
Telangiectases, head/neck, diathermy or injection of	30213,30214
Temperature, digital, measurement of	11615
Temporal artery, biopsy of	34109
bone, reconstruction of	45788
bone, removal of styloid process of	30244
bone, resection for removal of tumour	41584,41587
Temporomandibular joint, arthroplasty	45758
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*** Payable on attendance basis**

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*** Payable on attendance basis**

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*** Payable on attendance basis**

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*** Payable on attendance basis**

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*** Payable on attendance basis**

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*** Payable on attendance basis**

ORAL AND MAXILLOFACIAL SERVICES BY APPROVED DENTAL PRACTITIONERS

CATEGORY 4

PLEASE NOTE:

The information contained in this Category relates specifically to the Medicare Arrangements relating to Services by Approved Dental Practitioners. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the INTRODUCTION and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category. (The arrangements set out in the INTRODUCTION and GENERAL EXPLANATORY NOTES apply equally to Approved Dental Practitioners)

CATEGORY 4 - ORAL AND MAXILLOFACIAL SERVICES
(by Approved Dental Practitioners)

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CATEGORY 4 - ORAL AND MAXILLOFACIAL SERVICES

(by Approved Dental Practitioners)

OUTLINE OF ARRANGEMENTS

OA. INTRODUCTION

OA.1 Benefits for Medical Services by Dental Practitioners

Under the provisions of the Health Insurance Act 1973 (the Act), Medicare benefits are payable where an eligible person incurs medical expenses in respect of certain professional services rendered by a approved dental practitioner approved before 1 November 2004. Approved dental practitioners may also request certain diagnostic imaging services (see paragraph DID.2 of Category 5 Explanatory Notes).

OA.2 Changes to the Scheme Effective 1 November 2004

From 1 November 2004, access to Category 4 will be restricted to those dental practitioners who were approved by the Minister prior to 1 November 2004. No new approvals will be granted after that date.

Background

Since 2000, practitioners performing oral and maxillofacial surgery in Australia surgery in Australia are required to have both dental and medical qualifications in order to sit for their FRACDS(OMS) exam. This effectively means that since then, any practitioner who has obtained an FRACDS(OMS) or equivalent can access Category 3 of the MBS because they are medically qualified. The Government, in consultation with the Australian and New Zealand Association of Oral and Maxillofacial Surgeons, the Australian Dental Association, the Royal Australian College of Surgeons, the Royal Australian College of Dental Surgeons and the Australian Medical Association, has agreed that access by new practitioners to Category 4 will be withdrawn from 1 November 2004. Practitioners who were approved prior to that date will continue to have access to Category 4. The long-term proposal is that once all practitioners who currently access Category 4 have left the workforce, Category 4 will be removed from the Medicare Benefits Schedule.

Details of the services attracting Medicare benefits are set out in the Schedule following these explanatory notes.

OB. APPROVAL OF DENTAL PRACTITIONERS (ORAL AND MAXILLOFACIAL SURGEONS)

OB.1 Definition of Oral and Maxillofacial Surgery

Oral and Maxillofacial Surgery is defined as the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region.

OB.2 Services that can be provided

Dental practitioners holding the FRACDS (OMS) or equivalent who were approved by the Minister prior to 1 November 2004 may perform prescribed medical services (oral and maxillofacial surgery) listed in this category. All dental practitioners approved for the purposes of subsection 3(1) of the Act are also recognised to perform those items of oral and maxillofacial surgery listed in Group C2 of the booklet "Medicare Benefits for Treatment of Cleft Lip and Cleft Palate Conditions".

It is emphasised that -

(i) the sole purpose of granting approval to dental practitioners is to enable payment of Medicare benefits;

(ii) the services set out in Groups 01 to 011 of the Medicare Benefits Schedule book, and in the Cleft Lip and Cleft Palate Schedule are the only ones for which Medicare benefits are payable when the services are performed by an eligible dental practitioner.

EXPLANATORY NOTES

OC. INTERPRETATION OF THE SCHEDULE

OC.1 Principles of Interpretation

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

OC.2 Multiple Operation Rule

The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:-

100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE:

1. Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents
2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes all services in Groups O3 to O9.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

OC.3 After-care (Post-operative Treatment)

The fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided unless otherwise indicated. After-care is deemed to include all post-operative treatment rendered by practitioners and need not necessarily be limited to treatment given by the approved dental practitioner or to treatment given by any one practitioner. This does not preclude, however, the payment of benefit for professional services for the treatment by a dental practitioner of an intercurrent condition or an unusual complication arising from the operation.

Some minor operations are merely stages in the treatment of a particular condition. Professional services by dental practitioners subsequent to such operations should not be regarded as after-care but rather as continuation of the treatment of the original condition and should attract benefit. Item 52057 is a service to which this policy applies.

OC.4 Administration of Anaesthetics by Medical Practitioners

When a medical practitioner administers an anaesthetic in connection with a procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an approved dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

The Schedule fee for anaesthesia is established using the RVG schedule at Category 3 - Group T10. For the minimum requirements for claiming benefits under the RVG see Note T10.5 of Category 3.

Before the payment of benefits for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out in paragraph 7.1 of the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:

- The anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. Also, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and the total time of the anaesthesia;
- The assistant anaesthetist's account must show the name/s of the medical practitioners who performed the associated operation/s, as well as the name of the principle anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthesia.

OC.5 Consultations (Items 51700, 51703)

The consultation item numbers (51700 and 51703) are to be used by approved dental practitioners in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg scale and clean, construction of dentures, restorative dentistry or dental extraction).

OC.6 Assistance at Operations (Items 51800, 51803)

Items covering operations which are eligible for benefits for assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery or surgical assistance have been identified by the inclusion of the word "Assist" in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to an approved dental practitioner no additional benefits are payable. The assistance benefit is the same irrespective of the number of practitioners providing assistance.

Benefits payable under item 51800

Medicare benefits are payable under Item 51800 for assistance rendered at the following procedures:
51900, 51904, 52010, 52018, 52039, 52048, 52051, 52062, 52063, 52066, 52078, 52090, 52092, 52095, 52105, 52108, 52111, 52130, 52138, 52141, 52144, 52147, 52182, 52300, 52303, 52312, 52315, 52321, 52324, 52336, 52339, 52424, 52440, 52452, 52480, 52482, 52600, 52603, 52609, 52612, 52615, 52624, 52626, 52627, 52800, 52803, 52806, 52809, 52818, 52824, 52828, 52830, 53006, 53009, 53016, 53215, 53220, 53225, 53226, 53236, 53239, 53242, 53406, 53409, 53412, 53413, 53415, 53416, 53453, 53460.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under item 51300.

Benefits payable under Item 51803

51906, 52054, 52094, 52114, 52117, 52120, 52122, 52123, 52126, 52129, 52131, 52148, 52158, 52184, 52186, 52306, 52330, 52333, 52337, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52430, 52442, 52444, 52446, 52456, 52484, 52618, 52621, 52812, 52815, 52821, 52832, 53015, 53017, 53019, 53209, 53212, 53218, 53221, 53224, 53227, 53230, 53233, 53414, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53455.

or at a combination of procedures (including those identified as payable under item 51800 above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under Item 51303.

Assistance at multiple operations

Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Items 51800/51300 or 51803/51303).

The derived fee applicable to Item 51803/51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

OC.7 OPERATIONS (GROUPS 3 TO 9)

Repair of Wound (Item 51900)
Item 51900 covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

Lipectomy, Wedge Excision - Two or More Excisions (Item 51906)
Multiple lipectomies attract benefits under Item 51906 once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction.

Upper aerodigestive tract endoscopic procedures (Item 52035)
The following are guidelines of appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

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

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

Anaesthetic and resuscitation equipment
Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and

resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons. These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process (see paragraph 8.1 of the General Notes for Guidance).

Tumour, cyst, ulcer or scar (Items 52036 to 52054)
It is recognised that odontogenic keratocysts, although not neoplastic, often require the surgical management of benign tumours.

Aspiration of haematoma (Item 52056)
Aspiration of haematoma is indicated in clinical situations where incision may leave an unsightly scar or where access is difficult for conventional drainage.

Osteotomy of Jaw (Items 52342 - 52375)
The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 52318 or 52319 for the harvesting, plus item 52130 or 52131 for the grafting.

For the purposes of these items, a reference to maxilla includes the zygoma.

Genioplasty (Item 52378)
Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

Fracture of Mandible or Maxilla (Items 53400 - 53439)
There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones. Hence a bilateral fracture of the mandible would be assessed as, say Item 53409 x 1½; two maxillae and one side of the mandible as Item 53406 x 1½ + 53409 x ¼.

Splinting in Item 53406 or 53409 refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

OC.8 Diagnostic Procedures and Investigations (Group 10)
Skin sensitivity testing (Item 53600)
The allergens are local anaesthetics and the contents of anaesthetic capsules, acrylic and other polymers and metals.

OC.9 Regional or Field Nerve Blocks (Group 11)
Destruction of Nerve Branch by Neurolytic Agent (53706)
T7.7.1 This item includes the use of botulinum toxin as a neurolytic agent.

GROUP O1 - CONSULTATIONS

APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY

(Professional attendance at consulting rooms, hospital or residential aged care facility by an approved dental practitioner in the practice of oral and maxillofacial surgery where the patient is referred to him or her)

(The referral must be from a registered dental practitioner or a medical practitioner)

- INITIAL attendance in a single course of treatment
(See para OC.5 of explanatory notes to this Category)

51700 **Fee:** $74.05 **Benefit:** 75% = $55.55 85% = $62.95

- Each attendance SUBSEQUENT to the first in a single course of treatment
(See para OC.5 of explanatory notes to this Category)

51703 **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60

GROUP O2 - ASSISTANCE AT OPERATION

Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee does not exceed $483.20 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $483.20
I *(See para OC.6 of explanatory notes to this Category)*
51800 **Fee:** $74.70 **Benefit:** 75% = $56.05 85% = $63.50

Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee exceeds $483.20 or at a series or combination of operations identified by the word "Assist." where the aggregate fee exceeds $483.20
I *(See para OC.6 of explanatory notes to this Category)*
51803 **Derived Fee:** one fifth of the established fee for the operation or combination of operations

GROUP O3 - GENERAL SURGERY

WOUND OF SOFT TISSUE IN THE ORAL AND MAXILLOFACIAL REGION, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)
(See para OC.7 of explanatory notes to this Category)
51900 **Fee:** $282.15 **Benefit:** 75% = $211.65 85% = $239.85

WOUNDS, OF THE ORAL AND MAXILLOFACIAL REGION, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.)
51902 **Fee:** $63.95 **Benefit:** 75% = $48.00 85% = $54.40

LIPECTOMY - in the oral and maxillofacial region - wedge excision of skin or fat - 1 EXCISION (Anaes.) (Assist.)
51904 **Fee:** $393.65 **Benefit:** 75% = $295.25 85% = $334.65

LIPECTOMY - in the oral and maxillofacial region - wedge excision of skin or fat - 2 OR MORE EXCISIONS (Anaes.) (Assist.)
(See para OC.7 of explanatory notes to this Category)
51906 **Fee:** $598.75 **Benefit:** 75% = $449.10 85% = $537.25

SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.)
52000 **Fee:** $71.40 **Benefit:** 75% = $53.55 85% = $60.70

SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.)
52003 **Fee:** $101.70 **Benefit:** 75% = $76.30 85% = $86.45

SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.)
52006 **Fee:** $101.70 **Benefit:** 75% = $76.30 85% = $86.45

SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.)
52009 **Fee:** $160.70 **Benefit:** 75% = $120.55 85% = $136.60

52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $219.80	**Benefit:** 75% = $164.85	85% = $186.85
52012	SUPERFICIAL FOREIGN BODY, in the oral and maxillofacial region, removal of, as an independent procedure (Anaes.) **Fee:** $20.30	**Benefit:** 75% = $15.25	85% = $17.30
52015	SUBCUTANEOUS FOREIGN BODY, in the oral and maxillofacial region, removal of, requiring incision and suture, as an independent procedure (Anaes.) **Fee:** $95.10	**Benefit:** 75% = $71.35	85% = $80.85
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, in the oral and maxillofacial region, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $239.50	**Benefit:** 75% = $179.65	85% = $203.60
52021	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) **Fee:** $25.50	**Benefit:** 75% = $19.15	85% = $21.70
52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, in the oral and maxillofacial region, as an independent procedure (Anaes.) **Fee:** $45.20	**Benefit:** 75% = $33.90	85% = $38.45
52025	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $159.15	**Benefit:** 75% = $119.40	85% = $135.30
52027	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, in the oral and maxillofacial region, as an independent procedure and not being a service to which item 52025 applies (Anaes.) **Fee:** $129.60	**Benefit:** 75% = $97.20	85% = $110.20
52030	SINUS, in the oral and maxillofacial region, excision of, involving superficial tissue only (Anaes.) **Fee:** $77.85	**Benefit:** 75% = $58.40	85% = $66.20
52033	SINUS, in the oral and maxillofacial region, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $159.15	**Benefit:** 75% = $119.40	85% = $135.30
52034	PREMALIGNANT LESIONS of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser **Fee:** $37.15	**Benefit:** 75% = $27.90	85% = $31.60
52035	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions of the oral cavity (Anaes.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $412.05	**Benefit:** 75% = $309.05	85% = $350.55
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation),in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $109.85	**Benefit:** 75% = $82.40	85% = $93.40
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $282.15	**Benefit:** 75% = $211.65	85% = $239.85

52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $149.30	**Benefit:** 75% = $112.00	85% = $126.95
52045	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $213.30	**Benefit:** 75% = $160.00	85% = $181.35
52048	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $321.55	**Benefit:** 75% = $241.20	85% = $273.35
52051	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $434.70	**Benefit:** 75% = $326.05	85% = $373.20
52054	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $508.55	**Benefit:** 75% = $381.45	85% = $447.05
52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS IN THE ORAL AND MAXILLOFACIAL REGION, not requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding after care) **Fee:** $23.65	**Benefit:** 75% = $17.75	85% = $20.15
52056	HAEMATOMA IN THE ORAL AND MAXILLOFACIAL REGION, aspiration of (Anaes.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $23.65	**Benefit:** 75% = $17.75	85% = $20.15
52057	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion IN THE ORAL AND MAXILLOFACIAL REGION, requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) **Fee:** $141.05	**Benefit:** 75% = $105.80	85% = $119.90
52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS IN THE ORAL AND MAXILLOFACIAL REGION, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $205.65	**Benefit:** 75% = $154.25	85% = $174.85
52059	ABSCESS IN THE ORAL AND MAXILLOFACIAL REGION DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $231.65	**Benefit:** 75% = $173.75	85% = $196.95
52060	MUSCLE IN THE ORAL AND MAXILLOFACIAL REGION, excision of (Anaes.) **Fee:** $163.90	**Benefit:** 75% = $122.95	85% = $139.35
52061	MUSCLE, IN THE ORAL AND MAXILLOFACIAL REGION, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $193.55	**Benefit:** 75% = $145.20	85% = $164.55
52062	MUSCLE, IN THE ORAL AND MAXILLOFACIAL REGION, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $255.90	**Benefit:** 75% = $191.95	85% = $217.55

52063	BONE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $308.40	**Benefit:** 75% = $231.30	85% = $262.15
52064	BONE CYST IN THE ORAL AND MAXILLOFACIAL REGION, injection into or aspiration of (Anaes.) **Fee:** $146.70	**Benefit:** 75% = $110.05	85% = $124.70
52066	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) **Fee:** $385.50	**Benefit:** 75% = $289.15	85% = $327.70
52069	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $171.85	**Benefit:** 75% = $128.90	85% = $146.10
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $50.90	**Benefit:** 75% = $38.20	85% = $43.30
52073	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $129.60	**Benefit:** 75% = $97.20	85% = $110.20
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.) **Fee:** $129.60	**Benefit:** 75% = $97.20	85% = $110.20
52078	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $255.90	**Benefit:** 75% = $191.95	85% = $217.55
52081	TONGUE TIE, division or excision of frenulum (Anaes.) **Fee:** $40.25	**Benefit:** 75% = $30.20	85% = $34.25
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a person aged not less than 2 years (Anaes.) **Fee:** $103.40	**Benefit:** 75% = $77.55	85% = $87.90
52087	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $177.15	**Benefit:** 75% = $132.90	85% = $150.60
52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $308.40	**Benefit:** 75% = $231.30	85% = $262.15
52092	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) **Fee:** $402.00	**Benefit:** 75% = $301.50	85% = $341.70
52094	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 52092 (Anaes.) (Assist.) **Fee:** $508.50	**Benefit:** 75% = $381.40	85% = $447.00
52095	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.) **Fee:** $329.55	**Benefit:** 75% = $247.20	85% = $280.15
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.) **Fee:** $97.70	**Benefit:** 75% = $73.30	85% = $83.05
52097	EXTERNAL FIXATION IN THE ORAL AND MAXILLOFACIAL REGION, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $138.55	**Benefit:** 75% = $103.95	85% = $117.80
52098	EXTERNAL FIXATION IN THE ORAL AND MAXILLOFACIAL REGION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) **Fee:** $162.95	**Benefit:** 75% = $122.25	85% = $138.55

52099	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52102 or 52105 applies (Anaes.) **Fee:** $122.25	**Benefit:** 75% = $91.70	85% = $103.95
52102	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, where undertaken in the operating theatre of a hospital or approved day-hospital facility, per bone (Anaes.) **Fee:** $122.25	**Benefit:** 75% = $91.70	85% = $103.95
52105	PLATE, 1 or more of, and associated screw and wire which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52099 or 52102 applies (Anaes.) (Assist.) **Fee:** $228.15	**Benefit:** 75% = $171.15	85% = $193.95
52106	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $94.25	**Benefit:** 75% = $70.70	85% = $80.15
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.) **Fee:** $282.15	**Benefit:** 75% = $211.65	85% = $239.85
52111	VERMILIONECTOMY (Anaes.) (Assist.) **Fee:** $282.15	**Benefit:** 75% = $211.65	85% = $239.85
52114	MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $508.55	**Benefit:** 75% = $381.45	85% = $447.05
52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $605.35	**Benefit:** 75% = $454.05	85% = $543.85
52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes.) (Assist.) **Fee:** $713.60	**Benefit:** 75% = $535.20	85% = $652.10
52122	MANDIBLE, hemi-mandibular reconstruction of, OR MAXILLA, reconstruction of, with BONE GRAFT, PLATE, TRAY OR ALLOPLAST, not being a service associated with a service to which item 52123 applies (Anaes.) (Assist.) **Fee:** $715.95	**Benefit:** 75% = $537.00	85% = $654.45
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) **Fee:** $810.60	**Benefit:** 75% = $607.95	85% = $749.10
52126	MAXILLA, total resection of (Anaes.) (Assist.) **Fee:** $779.30	**Benefit:** 75% = $584.50	85% = $717.80
52129	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) **Fee:** $1,043.20	**Benefit:** 75% = $782.40	85% = $981.70
52130	BONE GRAFT IN THE ORAL AND MAXILLOFACIAL REGION, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $382.90	**Benefit:** 75% = $287.20	85% = $325.50
52131	BONE GRAFT WITH INTERNAL FIXATION, IN THE ORAL AND MAXILLOFACIAL REGION, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $529.65	**Benefit:** 75% = $397.25	85% = $468.15
52132	TRACHEOSTOMY (Anaes.) **Fee:** $206.70	**Benefit:** 75% = $155.05	85% = $175.70
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) **Fee:** $78.80	**Benefit:** 75% = $59.10	85% = $67.00
52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $124.95	**Benefit:** 75% = $93.75	85% = $106.25

52138	MAXILLARY ARTERY, ligation of (Anaes.) (Assist.) **Fee:** $385.50	**Benefit:** 75% = $289.15	85% = $327.70
52141	FACIAL, MANDIBULAR or LINGUAL ARTERY or VEIN or ARTERY and VEIN, ligation of, not being a service to which item 52138 applies (Anaes.) (Assist.) **Fee:** $384.00	**Benefit:** 75% = $288.00	85% = $326.40
52144	FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $357.90	**Benefit:** 75% = $268.45	85% = $304.25
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $337.70	**Benefit:** 75% = $253.30	85% = $287.05
52148	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $597.00	**Benefit:** 75% = $447.75	85% = $535.50
52158	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $961.25	**Benefit:** 75% = $720.95	85% = $899.75
	MALIGNANT DISEASE		
52180	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, biopsy of (not including aftercare) (Anaes.) **Fee:** $162.95	**Benefit:** 75% = $122.25	85% = $138.55
52182	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of (Anaes.) (Assist.) **Fee:** $358.55	**Benefit:** 75% = $268.95	85% = $304.80
52184	BONE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $529.65	**Benefit:** 75% = $397.25	85% = $468.15
52186	BONE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $651.90	**Benefit:** 75% = $488.95	85% = $590.40
	GROUP O4 - PLASTIC & RECONSTRUCTIVE		
52300	SINGLE-STAGE LOCAL FLAP, in the oral and maxillofacial region, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.) **Fee:** $246.10	**Benefit:** 75% = $184.60	85% = $209.20
52303	SINGLE-STAGE LOCAL FLAP, in the oral and maxillofacial region, where indicated, repair to 1 defect, with buccal pad of fat (Anaes.) (Assist.) **Fee:** $351.40	**Benefit:** 75% = $263.55	85% = $298.70
52306	SINGLE-STAGE LOCAL FLAP, in the oral and maxillofacial region, where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) **Fee:** $521.40	**Benefit:** 75% = $391.05	85% = $459.90
52309	FREE GRAFTING (mucosa or split skin) of a granulating area in the oral and maxillofacial region, (Anaes.) **Fee:** $177.15	**Benefit:** 75% = $132.90	85% = $150.60
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect in the oral and maxillofacial region, including elective dissection (Anaes.) (Assist.) **Fee:** $246.10	**Benefit:** 75% = $184.60	85% = $209.20
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) in the oral and maxillofacial region (Anaes.) (Assist.) **Fee:** $410.05	**Benefit:** 75% = $307.55	85% = $348.55

52318	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - small quantity (Anaes.) **Fee:** $122.25	**Benefit:** 75% = $91.70	85% = $103.95
52319	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - large quantity (Anaes.) **Fee:** $203.45	**Benefit:** 75% = $152.60	85% = $172.95
52321	FOREIGN IMPLANT (NON-BIOLOGICAL), insertion of in the oral and maxillofacial region, for CONTOUR RECONSTRUCTION of pathological deformity, not being a service associated with a service to which item 52624 applies (Anaes.) (Assist.) **Fee:** $410.05	**Benefit:** 75% = $307.55	85% = $348.55
52324	DIRECT FLAP REPAIR, using tongue, first stage (Anaes.) (Assist.) **Fee:** $410.05	**Benefit:** 75% = $307.55	85% = $348.55
52327	DIRECT FLAP REPAIR, using tongue, second stage (Anaes.) **Fee:** $203.45	**Benefit:** 75% = $152.60	85% = $172.95
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.) **Fee:** $676.75	**Benefit:** 75% = $507.60	85% = $615.25
52333	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $676.75	**Benefit:** 75% = $507.60	85% = $615.25
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.) **Fee:** $423.00	**Benefit:** 75% = $317.25	85% = $361.50
52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) **Fee:** $925.25	**Benefit:** 75% = $693.95	85% = $863.75
52339	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $481.75	**Benefit:** 75% = $361.35	85% = $420.25
52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $836.70	**Benefit:** 75% = $627.55	85% = $775.20
52345	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $943.65	**Benefit:** 75% = $707.75	85% = $882.15
52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,066.30	**Benefit:** 75% = $799.75	85% = $1,004.80
52351	MANDIBLE or MAXILLA, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,197.50	**Benefit:** 75% = $898.15	85% = $1,136.00
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,214.00	**Benefit:** 75% = $910.50	85% = $1,152.50

52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,366.75	**Benefit:** 75% = $1,025.10	85% = $1,305.25
52360	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,394.30	**Benefit:** 75% = $1,045.75	85% = $1,332.80
52363	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,568.55	**Benefit:** 75% = $1,176.45	85% = $1,507.05
52366	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,533.90	**Benefit:** 75% = $1,150.45	85% = $1,472.40
52369	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,724.60	**Benefit:** 75% = $1,293.45	85% = $1,663.10
52372	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,673.40	**Benefit:** 75% = $1,255.05	85% = $1,611.90
52375	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $1,874.40	**Benefit:** 75% = $1,405.80	85% = $1,812.90
52378	GENIOPLASTY including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $647.95	**Benefit:** 75% = $486.00	85% = $586.45
52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.) (Assist.) **Fee:** $1,106.35	**Benefit:** 75% = $829.80	85% = $1,044.85
52380	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) **Fee:** $1,885.55	**Benefit:** 75% = $1,414.20	85% = $1,824.05
52382	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) **Fee:** $2,260.25	**Benefit:** 75% = $1,695.20	85% = $2,198.75
52420	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $208.70	**Benefit:** 75% = $156.55	85% = $177.40

52424	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) IN THE ORAL AND MAXILLOFACIAL REGION (Anaes.) (Assist.) **Fee:** $409.95	**Benefit:** 75% =$307.50	85% =$348.50
52430	MICROVASCULAR REPAIR OF THE ORAL AND MAXILLOFACIAL REGION using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) **Fee:** $943.65	**Benefit:** 75% =$707.75	85% =$882.15
52440	CLEFT LIP, unilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $468.55	**Benefit:** 75% =$351.45	85% =$407.05
52442	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $585.80	**Benefit:** 75% =$439.35	85% =$524.30
52444	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $650.75	**Benefit:** 75% =$488.10	85% =$589.25
52446	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $768.05	**Benefit:** 75% =$576.05	85% =$706.55
52450	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $260.30	**Benefit:** 75% =$195.25	85% =$221.30
52452	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $423.00	**Benefit:** 75% =$317.25	85% =$361.50
52456	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $715.95	**Benefit:** 75% =$537.00	85% =$654.45
52458	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $260.30	**Benefit:** 75% =$195.25	85% =$221.30
52460	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $676.75	**Benefit:** 75% =$507.60	85% =$615.25
52480	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $434.70	**Benefit:** 75% =$326.05	85% =$373.20
52482	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $418.25	**Benefit:** 75% =$313.70	85% =$356.75
52484	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $497.90	**Benefit:** 75% =$373.45	85% =$436.40
	GROUP O5 - PREPROSTHETIC		
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $292.80	**Benefit:** 75% =$219.60	85% =$248.90
52603	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $279.90	**Benefit:** 75% =$209.95	85% =$237.95
52606	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $213.50	**Benefit:** 75% =$160.15	85% =$181.50
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) **Fee:** $279.90	**Benefit:** 75% =$209.95	85% =$237.95
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) **Fee:** $351.40	**Benefit:** 75% =$263.55	85% =$298.70

52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) **Fee:** $436.10 **Benefit:** 75% = $327.10 85% = $374.60
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $507.55 **Benefit:** 75% = $380.70 85% = $446.05
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) **Fee:** $507.55 **Benefit:** 75% = $380.70 85% = $446.05
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $409.95 **Benefit:** 75% = $307.50 85% = $348.50
52626	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) **Fee:** $251.40 **Benefit:** 75% = $188.55 85% = $213.70
52627	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.) **Fee:** $436.10 **Benefit:** 75% = $327.10 85% = $374.60
52630	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.) **Fee:** $161.40 **Benefit:** 75% = $121.05 85% = $137.20
52633	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $436.10 **Benefit:** 75% = $327.10 85% = $374.60
52636	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $161.40 **Benefit:** 75% = $121.05 85% = $137.20
	GROUP O6 - NEUROSURGICAL
52800	NEUROLYSIS BY OPEN OPERATION, in the oral and maxillofacial region, without transposition, not being a service associated with a service to which item 52803 applies (Anaes.) (Assist.) **Fee:** $239.50 **Benefit:** 75% = $179.65 85% = $203.60
52803	NERVE TRUNK, internal (interfascicular), in the oral and maxillofacial region, NEUROLYSIS of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $344.90 **Benefit:** 75% = $258.70 85% = $293.20
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve in the oral and maxillofacial region (Anaes.) (Assist.) **Fee:** $239.50 **Benefit:** 75% = $179.65 85% = $203.60
52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve in the oral and maxillofacial region (Anaes.) (Assist.) **Fee:** $410.05 **Benefit:** 75% = $307.55 85% = $348.55
52812	NERVE TRUNK, in the oral and maxillofacial region, PRIMARY repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $585.80 **Benefit:** 75% = $439.35 85% = $524.30
52815	NERVE TRUNK, in the oral and maxillofacial region, SECONDARY repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $618.20 **Benefit:** 75% = $463.65 85% = $556.70
52818	NERVE, in the oral and maxillofacial region, TRANSPOSITION OF (Anaes.) (Assist.) **Fee:** $410.05 **Benefit:** 75% = $307.55 85% = $348.55
52821	NERVE GRAFT TO NERVE TRUNK in the oral and maxillofacial region (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) **Fee:** $891.60 **Benefit:** 75% = $668.70 85% = $830.10

52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) **Fee:** $384.00	**Benefit:** 75% =$288.00	85% =$326.40
52826	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) **Fee:** $205.65	**Benefit:** 75% =$154.25	85% =$174.85
52828	CUTANEOUS NERVE, in the oral and maxillofacial region, primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $305.85	**Benefit:** 75% =$229.40	85% =$260.00
52830	CUTANEOUS NERVE, in the oral and maxillofacial region, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $403.40	**Benefit:** 75% =$302.55	85% =$342.90
52832	CUTANEOUS NERVE, in the oral and maxillofacial region, nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $553.20	**Benefit:** 75% =$414.90	85% =$491.70
	GROUP O7 - EAR, NOSE & THROAT		
53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $28.10	**Benefit:** 75% =$21.10	85% =$23.90
53003	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $79.60	**Benefit:** 75% =$59.70	85% =$67.70
53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $29.05	**Benefit:** 75% =$21.80	85% =$24.70
53006	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) **Fee:** $451.10	**Benefit:** 75% =$338.35	85% =$389.60
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $255.90	**Benefit:** 75% =$191.95	85% =$217.55
53012	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $101.70	**Benefit:** 75% =$76.30	85% =$86.45
53015	ORO-ANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) **Fee:** $508.55	**Benefit:** 75% =$381.45	85% =$447.05
53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.) **Fee:** $418.25	**Benefit:** 75% =$313.70	85% =$356.75
53017	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) **Fee:** $521.80	**Benefit:** 75% =$391.35	85% =$460.30
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) **Fee:** $502.70	**Benefit:** 75% =$377.05	85% =$441.20
53052	POST-NASAL SPACE, direct examination of, with or without biopsy (Anaes.) **Fee:** $106.30	**Benefit:** 75% =$79.75	85% =$90.40
53054	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.) **Fee:** $106.25	**Benefit:** 75% =$79.70	85% =$90.35
53056	EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $62.25	**Benefit:** 75% =$46.70	85% =$52.95

53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) **Fee:** $106.25	**Benefit:** 75% = $79.70	85% = $90.35
53060	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES FOR OBSTRUCTION OR HAEMORRHAGE SECONDARY TO SURGERY (OR TRAUMA) - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) **Fee:** $86.95	**Benefit:** 75% = $65.25	85% = $73.95
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $77.85	**Benefit:** 75% = $58.40	85% = $66.20
53064	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) **Fee:** $141.05	**Benefit:** 75% = $105.80	85% = $119.90
53068	TURBINECTOMY or TURBINECTOMIES, partial or total, unilateral (Anaes.) **Fee:** $116.75	**Benefit:** 75% = $87.60	85% = $99.25
53070	TURBINATES, submucous resection of, unilateral (Anaes.) **Fee:** $154.05	**Benefit:** 75% = $115.55	85% = $130.95
	GROUP O8 - TEMPOROMANDIBULAR JOINT		
53200	MANDIBLE, treatment of a dislocation of, not requiring open reduction (Anaes.) **Fee:** $61.20	**Benefit:** 75% = $45.90	85% = $52.05
53203	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) **Fee:** $102.80	**Benefit:** 75% = $77.10	85% = $87.40
53206	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $123.70	**Benefit:** 75% = $92.80	85% = $105.15
53209	GLENOID FOSSA, ZYGOMATIC ARCH and TEMPORAL BONE, reconstruction of (Obwegeser technique) (Anaes.) (Assist.) **Fee:** $1,427.25	**Benefit:** 75% = $1,070.45	85% = $1,365.75
53212	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $771.00	**Benefit:** 75% = $578.25	85% = $709.50
53215	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) **Fee:** $353.70	**Benefit:** 75% = $265.30	85% = $300.65
53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes.) (Assist.) **Fee:** $565.80	**Benefit:** 75% = $424.35	85% = $504.30
53220	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $285.25	**Benefit:** 75% = $213.95	85% = $242.50
53221	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $754.95	**Benefit:** 75% = $566.25	85% = $693.45
53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $836.90	**Benefit:** 75% = $627.70	85% = $775.40

53225	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $251.40	**Benefit:** 75% = $188.55	85% = $213.70
53226	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $270.30	**Benefit:** 75% = $202.75	85% = $229.80
53227	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,028.35	**Benefit:** 75% = $771.30	85% = $966.85
53230	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,158.40	**Benefit:** 75% = $868.80	85% = $1,096.90
53233	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 53224, 53226, 53227 and 53230 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,301.65	**Benefit:** 75% = $976.25	85% = $1,240.15
53236	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $407.35	**Benefit:** 75% = $305.55	85% = $346.25
53239	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $407.35	**Benefit:** 75% = $305.55	85% = $346.25
53242	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $270.30	**Benefit:** 75% = $202.75	85% = $229.80
	GROUP O9 - TREATMENT OF FRACTURES		
53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting *(See para OC.7 of explanatory notes to this Category)* **Fee:** $111.80	**Benefit:** 75% = $83.85	85% = $95.05
53403	MANDIBLE, treatment of fracture of, not requiring splinting *(See para OC.7 of explanatory notes to this Category)* **Fee:** $136.60	**Benefit:** 75% = $102.45	85% = $116.15
53406	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $351.95	**Benefit:** 75% = $264.00	85% = $299.20
53409	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $351.95	**Benefit:** 75% = $264.00	85% = $299.20
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction *(See para OC.7 of explanatory notes to this Category)* **Fee:** $74.15	**Benefit:** 75% = $55.65	85% = $63.05
53411	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $206.70	**Benefit:** 75% = $155.05	85% = $175.70

53412	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $339.35	**Benefit:** 75% = $254.55	85% = $288.45
53413	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $414.70	**Benefit:** 75% = $311.05	85% = $353.20
53414	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $477.55	**Benefit:** 75% = $358.20	85% = $416.05
53415	MAXILLA, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $377.10	**Benefit:** 75% = $282.85	85% = $320.55
53416	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $377.10	**Benefit:** 75% = $282.85	85% = $320.55
53418	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $490.15	**Benefit:** 75% = $367.65	85% = $428.65
53419	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $490.15	**Benefit:** 75% = $367.65	85% = $428.65
53422	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $622.05	**Benefit:** 75% = $466.55	85% = $560.55
53423	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $622.05	**Benefit:** 75% = $466.55	85% = $560.55
53424	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $533.70	**Benefit:** 75% = $400.30	85% = $472.20
53425	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $533.70	**Benefit:** 75% = $400.30	85% = $472.20
53427	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $728.95	**Benefit:** 75% = $546.75	85% = $667.45
53429	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $728.95	**Benefit:** 75% = $546.75	85% = $667.45
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) *(See para OC.7 of explanatory notes to this Category)* **Fee:** $206.70	**Benefit:** 75% = $155.05	85% = $175.70

53453	ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.) **Fee:** $418.25 **Benefit:** 75% =$313.70 85% =$356.75
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) **Fee:** $491.30 **Benefit:** 75% =$368.50 85% =$429.80
53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies **Fee:** $37.20 **Benefit:** 75% =$27.90 85% =$31.65
53459	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $203.75 **Benefit:** 75% =$152.85 85% =$173.20
53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.) **Fee:** $415.70 **Benefit:** 75% =$311.80 85% =$354.20
	GROUP O10 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
53600	SKIN SENSITIVITY TESTING for allergens to anaesthetics and materials used in OMS surgery, USING 1 TO 20 ALLERGENS *(See para OC.7 of explanatory notes to this Category)* **Fee:** $33.70 **Benefit:** 75% =$25.30 85% =$28.65
	GROUP O11 - REGIONAL OR FIELD NERVE BLOCKS
53700	(Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.)) TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent **Fee:** $108.05 **Benefit:** 75% =$81.05 85% =$91.85
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent **Fee:** $54.10 **Benefit:** 75% =$40.60 85% =$46.00
53704	FACIAL NERVE, injection of an anaesthetic agent **Fee:** $32.55 **Benefit:** 75% =$24.45 85% =$27.70
53706	NERVE BRANCH IN THE ORAL AND MAXILLOFACIAL REGION, destruction by a neurolytic agent, not being a service to which any other item in this Group applies *(See para OC.7 of explanatory notes to this Category)* **Fee:** $108.05 **Benefit:** 75% =$81.05 85% =$91.85

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DIAGNOSTIC IMAGING SERVICES

CATEGORY 5

PLEASE NOTE:

The information contained in this Category relates specifically to the Diagnostic Imaging Services Arrangements under Medicare. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the INTRODUCTION and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category.

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CATEGORY 5 - DIAGNOSTIC IMAGING SERVICES

DIA OVERVIEW

Section 4AA of the *Health Insurance Act 1973* (the Act) enables the *Health Insurance (Diagnostic Imaging Services Table) Regulations* to prescribe a table of diagnostic imaging services that sets out rules for interpretation of the table, items of diagnostic imaging services and the amount of fees applicable to each item.

The management of the Diagnostic Imaging Services Table (DIST) is undertaken cooperatively between the Commonwealth (as represented by the Department of Health and Ageing) and representative diagnostic imaging professions. This is done through agreements known as Quality and Outlays Memoranda of Understanding (MoUs) which commenced on 1 July 2003 for five years. There are four MoUs: *Radiology, Cardiac Imaging, Nuclear Medicine* and *Obstetric and Gynaecological Ultrasound* and the following diagnostic imaging professional groups are parties to the MoUs:

Radiology MoU
Royal Australian and New Zealand College of Radiologists (RANZCR) &
Australian Diagnostic Imaging Association (ADIA)

Cardiac Imaging MoU
Cardiac Society of Australia and New Zealand (CSANZ)

Nuclear Medicine MoU
Australian and New Zealand Association of Physicians in Nuclear Medicine (ANZAPNM)

Obstetric and Gynaecological Ultrasound MoU
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and RANZCR

For further information on diagnostic imaging and the MOUs visit the Department of Health and Ageing website at www.health.gov.au

DIB WHAT IS A DIAGNOSTIC IMAGING SERVICE

A diagnostic imaging service is defined in the Act as meaning "an R-type diagnostic imaging service or an NR-type diagnostic imaging service to which an item in the DIST applies".

A diagnostic imaging procedure is defined in the Act as 'a procedure for the production of images (for example x-rays, computerised tomography scans, ultrasound scans, magnetic resonance imaging scans and nuclear scans) for use in the rendering of diagnostic imaging services'.

The Schedule fee for each diagnostic imaging service described in the DIST covers both the diagnostic imaging procedure and the reading and report on that procedure by the diagnostic imaging service provider. Exceptions to the reporting requirement are as follows:

(a) where the service is provided in conjunction with a surgical procedure, the findings may be noted on the operation record (items 55054, 55130, 55848, 55850, 57341, 57345, 59312, 59314, 60506, 60509 and 61109);
(b) where a service is provided in preparation of a radiological procedure (items 60918 and 60927).

As for all Medicare services, diagnostic imaging services have to be clinically relevant before they are eligible for Medicare benefits. A clinically relevant service is a service that is generally accepted in the profession as being necessary for the appropriate treatment of the patient.

For NR-type services (and R-type services provided without a request under the exemption provisions – see DID.4), the clinical relevance of the service is determined by the **providing practitioner**. For R-type services rendered at the request of another practitioner, responsibility for determining the clinical relevance of the service lies with the **requesting practitioner.**

DIC WHO MAY PROVIDE A DIAGNOSTIC IMAGING SERVICE

Unless otherwise stated, a diagnostic imaging service specified in the DIST may be provided by:

(a) a medical practitioner; or
(b) a person, other than a medical practitioner, who:
    (i) is employed by a medical practitioner; or

(ii) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

For the purposes of Medicare, however, the rendering practitioner is the medical practitioner who provides the report.

Medicare benefits are not payable, for example, when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers or other persons, who either bill the patient or the practitioner requesting the service.

DIC.1 Reports provided by practitioners located outside Australia

Under the Act, Medicare benefits are only payable for services rendered in Australia. Where a service consists of a number of components, such as a diagnostic imaging service, all components need to be rendered in Australia in order to qualify for Medicare benefits. For diagnostic imaging services, this means that all elements of the service, including the preparation of report on the procedure, would need to be rendered in Australia.

As such, Medicare benefits are not payable for services which have been reported on by medical practitioners located outside Australia.

DID REQUESTS FOR DIAGNOSTIC IMAGING SERVICES

DID.1 Request requirements

Medicare benefits are not payable for diagnostic imaging services that are classified as R-type (requested) services unless prior to commencing the relevant service, the practitioner receives a signed and dated request from a requesting practitioner who determined the service was necessary.

Before requesting a diagnostic imaging service, the requesting practitioner must turn his or her mind to the clinical relevance of the request and determine that the service is necessary for the appropriate professional care of the patient. For example: an ultrasound to determine the sex of a foetus is not a clinically relevant service (unless there is an indication that the sex of the foetus will determine further courses of treatment, eg. a genetic background to a sex-related disease or condition).

There are exemptions to the request requirements in specified circumstances. These circumstances are detailed under 'Exemptions from the written request requirements for R-type diagnostic imaging services' – see DID.4.

DID.2 Who may request a diagnostic imaging service

The following practitioners may request a diagnostic imaging service:

- Specialists and consultant physicians can request any diagnostic imaging service.
- Other medical practitioners can request any service except Magnetic Resonance Imaging Services – see DIO.2.
- A medical practitioner, on behalf of the requesting practitioner, for example, by a resident medical officer at a hospital on behalf of the patient's practitioner.
- Dental Practitioners, Physiotherapists, Chiropractors, Osteopaths and Podiatrists registered or licensed under State or Territory laws can request the following diagnostic imaging services:

  All dental practitioners may request the following items:

  57509, 57515, 57521, 57527, 57901, 57902, 57903, 57906, 57909, 57912, 57915, 57918, 57921, 57924, 57927, 57930, 57933, 57939, 57942, 57945, 57960, 57963, 57966, 57969, 58100, 58300, 58503, 58903, 59733, 59739, 59751, 60100, 60500, 60503.

  In addition to these items, oral and maxillofacial surgeons, prosthodontists, dental specialists (periodontists, endodontists, pedodontists, orthodontists) and specialists in oral medicine and oral pathology are also able to request the following items:

Oral and maxillofacial surgeons

55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56030, 56036, 56041, 56047 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56101, 56107, 56141, 56147, 56219, 56220, 56224, 56227, 56230, 56259, 56301, 56307, 56341, 56347, 56401, 56407, 56409, 56412, 56441, 56447, 56449, 56452, 56501, 56507, 56541, 56547, 56801, 56807, 56841, 56847, 57001, 57007, 57041, 57047, 57341, 57345, 57703, 57709, 57712, 57715, 58103, 58106, 58108, 58109, 58112, 58115, 58306, 58506, 58521, 58524, 58527, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007, 63334.

Prosthodontists

55028, 56013, 56016, 56022, 56028, 56053, 56056, 56062, 56068, 58306, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63334.

Dental specialists (periodontists, endodontists, pedeodontists, orthodontists).

56022, 56062, 58306, 61421, 61454, 61457, 63334.

Specialists in oral medicine and/or oral pathology

55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56041, 56047, 56050, 56053, 56056, 56062, 56068, 56101, 56107, 56141, 56147, 56301, 56307, 56341, 56347, 56401, 56407, 56441, 56447, 57341, 57345, 58306, 58506, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007, 63334.

Physiotherapists, Chiropractors and Osteopaths may request:

57712, 57715, 58100 to 58115 (inclusive).

Podiatrists may request:

57521, 57527.

DID.3 Form of a request

Responsibility for the adequacy of requesting details rests with the requesting practitioner.

A request for a diagnostic imaging service does not have to be in a particular form. However, the legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service.

The provision of additional relevant clinical information can often assist the service provider and enhance the overall service provided to the patient. As such, this practice is actively encouraged.

A written request must be signed and dated and contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner.

DID.3.1 Referral to specified provider not required

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

DID.3.2 Request for more than one service and limit on time to render services

The requesting practitioner may use a single request to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after the rendering of the first service.

DID.3.3 Contravention of request requirements

- A practitioner who, without reasonable excuse makes a request for a diagnostic imaging service that does not include the

required information in his or her request or in a request made on his or her behalf is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000; or

- A practitioner who renders "R-type" diagnostic imaging services and who, without reasonable excuse, provides either directly or indirectly to a requesting practitioner a document to be used in the making of a request which would contravene the request information requirements is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

DID.4 Exemptions from the written request requirements for R-type diagnostic imaging services

There are exemptions from the general written request requirements (R-type) diagnostic imaging services. These are outlined below.

DID.4.1 Consultant physician or specialist

A consultant physician or specialist is a medical practitioner recognised for the purposes of the *Health Insurance Act 1973* as a specialist or consultant physician, in a particular specialty.

Except for R-type items which in their description state that a referral is required (such as most R-type items in General Ultrasound and items 59300, 59303)**,** a written request is **not** required for the payment of Medicare benefits when the diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) in his or her specialty and after clinical assessment he/she determines that the service was necessary. For details required for accounts/receipts see DIF.

However, if in the referral to the consultant physician or specialist, the referring practitioner specifically requests a diagnostic imaging service (eg to a cardiologist to perform an echocardiogram) the service provided is a requested, not self-determined service. If further services are subsequently provided, these further services are self-determined – see DID.4.2 *"Additional services".*

DID.4.2 Additional services

A written request is not required for a diagnostic imaging service if that service was provided after one which has been formally requested and the providing practitioner determines that, on the basis of the results obtained from the requested service, that an additional service was necessary. However, the following services cannot be self- determined as "additional services":

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required;
- MRI services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see DIF.

DID.4.3 Substituted services

A provider may substitute a service for the service originally requested when:

- the provider determines, from the clinical information provided on the request, that the substituted service would be more appropriate for the diagnosis of the patient's condition; and
- the provider has consulted with the requesting practitioner or taken all reasonable steps to do so before providing the substituted service; and
- the substituted service was one that would be accepted as a more appropriate service in the circumstances by the practitioner's speciality group.

However, the following services cannot be substituted:

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required;
- MRI services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see DIF.

DID.4.4 Remote areas

A written request is not required for the payment of Medicare benefits for a R-type diagnostic imaging service rendered by a medical practitioner in a remote area provided:

- the R-type service is not one for which there is a corresponding NR-type service; and
- the medical practitioner rendering the service has been granted a remote area exemption for that service.

For details required for accounts/receipts see DIF.

Definition of remote area

The definition of a remote area is one that is more than 30 kilometres by road from:

(a) a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; and

(b) a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

Application for remote area exemption

A medical practitioner, other than a consultant physician or specialist, who believes that he or she qualifies for exemption under the remote area definition, should obtain an application form from Medicare Australia's website www.medicareaustralia.gov.au or by contacting Medicare Australia, Provider Liaison Section, on 132150 for the cost of a local call.

Quality assurance requirement for remote area exemption

Application for, or continuation of, a remote area exemption will be contingent on practitioners being enrolled in an approved continuing medical education and quality assurance program. For further information, please contact the Australian College of Rural and Remote Medicine (ACRRM) on (07) 3105 8200.

DID.4.5 Emergencies

The written request requirement does not apply if the providing practitioner determines that, because the need for the service arose in an emergency, the service should be performed as quickly as possible.

For details required for accounts/receipts see DIF.

DID.4.6 Lost requests

The written request requirement does not apply where:

- the person who received the diagnostic imaging service, or someone acting on that person's behalf, claimed that a written request had been made for such a service but that the request had been lost; and
- the provider of the diagnostic imaging service or that provider's agent or employee obtained confirmation from the requesting practitioner that the request had been made.

The lost request exemption is applicable only to services that the practitioner could originally request.

For details required for accounts/receipts see DIF.

DID.4.7 Pre-existing diagnostic imaging practices

The legislation provides for exemption from the written request requirement for services provided by practitioners who have operated pre-existing diagnostic imaging practices. The exemption applies to the services covered by the following Items: 57712, 57715, 57901, 57902, 57903, 57912, 57915, 57921, 58100, 58103, 58106, 58108, 58109, 58112, 58115, 58521, 58524, 58527, 58700, 58924 and 59103.

To qualify for this "grandparent" exemption the providing practitioner must:

(a) be treating his or her own patient;

(b) have determined that the service was necessary;
(c) have rendered between 17 October 1988 and 16 October 1990 at least 50 services (which resulted in the payment of Medicare benefits) of the kind which have been designated "R-type" services from 1 May 1991;
(d) provide the exempted services at the practice location where the services which enabled the practitioner to qualify for the "grandparent" exemption were rendered; and
(e) be enrolled in an approved continuing medical education and quality assurance program from 1 January 2001. For further information, please contact the Royal Australian College of General Practitioners (RACGP) on (03) 8699 0414 or Australian College of Rural and Remote Medicine (ACRRM) on (07) 3105 8200.

Benefits are only payable for services exempted under these provisions where the service was provided by the exempted medical practitioner at the exempted location. Exemptions are not transferable.

For details required for accounts/receipts see DIF.

DID.5 Retention of requests

A practitioner who has rendered an R-type diagnostic imaging service in response to a written request must retain that request for a period of 18 months commencing on the day on which the service was rendered.

A medical practitioner must, if requested by the Managing Director, Medicare Australia, produce written requests retained by that practitioner for an R-type diagnostic imaging service as soon as practicable or by the end of the day after the day on which the Managing Director's request was made.

The officer of Medicare Australia is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations of lost requests.

A medical practitioner who, without reasonable excuse, fails to comply with the above requirements is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

DIE REGISTRATION OF SITES UNDERTAKING DIAGNOSTIC IMAGING PROCEDURES

All sites (including hospitals) and bases for mobile equipment at or from which diagnostic imaging procedures are performed need to be registered with Medicare Australia for the purposes of Medicare.

Registered sites and bases for mobile equipment are allocated a Location Specific Practice Number (LSPN). The LSPN is a unique identifier comprising a six digit numeric and is required on all accounts, receipts and Medicare assignment of benefits forms for diagnostic imaging services before patients can receive Medicare benefits. In addition, benefits are not payable unless there is equipment of appropriate type listed on the register for the practice.

Sites or bases for mobile equipment need only register once. To maintain registration, sites are required to advise Medicare Australia of any changes to their primary information within 28 days of the change occurring. Primary information is:

- proprietor details;
- ACN (for companies);
- business name and ABN;
- address of practice site or base for mobile equipment;
- type of equipment located at the site;
- information about any health care provider not employed at, or contracted to provide services for the site or base, who has an interest in any of the equipment listed on the register.

Every 12 months, Medicare Australia will send the proprietor or authorised representative details of the information contained on the register for the practice site or base for mobile equipment. These details need to be either confirmed or updated (if necessary).

Registration will be suspended if a proprietor fails to respond to notices from Medicare Australia about registration details. . The suspension will be lifted as soon as the notices are responded to and Medicare benefits will be backdated for the period of suspension.

Registration will be cancelled after a continuous period of three months suspension. Cancellation under these circumstances is taken to have commenced from the date of suspension.

The proprietor may, at any time, request cancellation of the registration of a practice site or base for mobile equipment. Otherwise, registration may be cancelled by Medicare Australia if the registration was obtained improperly (false information supplied) or if the proprietor fails to notify Medicare Australia of primary information. A decision to cancel a registration will only be made following due consideration of a submission by the site or base. The proprietor may apply to the Administrative Appeals Tribunal for a review of this decision. If registration is cancelled involuntarily, the proprietor may not apply to re-register the site or base for a period of 12 months unless permitted to do so.

Proprietors of unregistered practices (including where the registration is under suspension or has been cancelled) need to either advise patients in writing or display a notice that no Medicare benefits will be payable for the diagnostic imaging services.

For full details about Location Specific Practice Numbers, including how to register a practice site, please visit www.medicareaustralia.gov.au/providers/forms/medicare/lspn.htm. A list of LSPN registrations is available on Medicare Australia's website at www.medicaraustralia.gov.au/yourhealth/ourservices/lspnsearch.htm and this allows practitioners and the general public to verify the registration status of practice sites eligible for Medicare benefits.

DIF DETAILS REQUIRED ON ACCOUNTS, RECEIPTS AND MEDICARE ASSIGNMENT OF BENEFITS FORMS

In addition to the normal particulars of the patient, date of service, the services performed and the fees charged, the details which must be entered on accounts or receipts, and Medicare assignment of benefits forms in respect of diagnostic imaging services are as follows:

- the Location Specific Practice Number (LSPN) of the diagnostic imaging premises or mobile facility where the diagnostic imaging procedure was undertaken;
- if the professional service is provided by a specialist in diagnostic radiology the name and either the address of the place of practice, or the provider number, of that specialist;
- if the medical practitioner is not a specialist in diagnostic radiology the name and either the practice address or provider number of the practitioner who is claiming or receiving fees;
- for "R-type" (requested) services and services rendered subsequent to lost requests, the account or receipt or the Medicare assignment form must indicate the date of the request and the name and provider number, or the name and address, of the requesting practitioner.
- services that are *self-determined*, that is, not provided following a specific request from another practitioner, must be endorsed with the letters "SD" to indicate that the service was self-determined. Services are classified as self determined when rendered:
  - by a *consultant physician or specialist*, in the course of that consultant physician or specialist practicing his or her specialty (other than a specialist in diagnostic radiology), or
  - to provide *additional services* to those specified in the original request and the additional services are of the type that would have otherwise required a referral from a specialist or consultant physician; or
  - in a *remote area*, or
  - under a *pre-existing diagnostic imaging practice exemption.*
- *substituted services* the account etc. must be endorsed 'SS'.
- *emergencies*, the account etc. must be endorsed "emergency".
- *lost requests* the account etc. must be endorsed "lost request".

DIG MAINTAINING RECORDS OF DIAGNOSTIC IMAGING SERVICES

Providers of diagnostic imaging services must keep records of diagnostic imaging services in a manner that facilitates retrieval on the basis of the patient's name and date of service. Records of R-type diagnostic imaging services must be retained for a period of 18 months commencing on the day on which the service was rendered.

The records must include the report by the providing practitioner on the diagnostic imaging service. For ultrasound services, where the service is performed on behalf of a medical practitioner the report must record the name of the sonographer.

- Where the provider *substitutes* a service for the service originally requested, the provider's records must include:

  - words indicating that the providing practitioner has consulted with the requesting practitioner and the date of consultation; or
  - if the providing practitioner has not consulted with the requesting practitioner, sufficient information to demonstrate that he or she has taken all reasonable steps to do so.

- For services rendered after a *lost request*, the records must include words to the effect that the request was lost but confirmed by the requesting practitioner and the manner of confirmation, eg. how and when.

- For *emergency services*, the records must indicate the nature of the emergency.

If requested by the Managing Director, Medicare Australia, records retained by a providing practitioner must be produced to an officer of Medicare Australia as soon as practicable but in any event within seven days after the day the Managing Director requests the production of those records. Medicare Australia officers may make and retain copies, or take and retain extracts, of such records.

A medical practitioner who, without reasonable excuse, contravenes any of the above provisions is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

DIH CONTRAVENTION OF STATE AND TERRITORY LAWS AND DISQUALIFIED PRACTITIONERS

Medicare benefits are not payable where a diagnostic imaging service is provided by, or on behalf of, a medical practitioner, and the provision of that service by that practitioner or any other person contravenes a State or Territory law which, directly or indirectly, relates to the use of diagnostic imaging procedures or equipment. The Managing Director of Medicare Australia may notify the relevant State or Territory authorities if he/she believes that a person may have contravened a law of a State or Territory relating directly or indirectly to the use of diagnostic imaging procedures or equipment.

DII PROHIBITED PRACTICES

For Medicare benefit purposes, a person is taken to be engaged in a prohibited diagnostic practice in the following circumstances:

- A "service provider" (being a person who renders a diagnostic imaging service or an employer of that person or who carries on the business of rendering diagnostic imaging services or an employer of that person or is the proprietor of premises at which diagnostic imaging services are rendered):

  - directly or indirectly offers any inducement (whether by way of money, property or other benefit or advantage), in order to encourage a practitioner to request the rendering of a diagnostic imaging service, or threatens any detriment or disadvantage, to a practitioner or any other person in order to encourage the practitioner to request the rendering of a diagnostic imaging service; or
  - directly or indirectly invites a practitioner to request the rendering of a diagnostic imaging service; or
  - directly or indirectly undertakes any act or thing that the person knows, or ought reasonably to know, is likely to have the effect of encouraging a practitioner to request the rendering of a diagnostic imaging service.

- A practitioner:

  - accepts a request from another practitioner to render a diagnostic imaging service and, in respect of any service (including a service for the use of diagnostic imaging equipment) connected with the rendering of the diagnostic imaging service, makes a payment, directly or indirectly to the other practitioner or if the diagnostic imaging service is not provided in a hospital - to a person who is the other practitioner's employer or to an employee of such a person; or
  - accepts a request from another practitioner to render a diagnostic imaging service where there is in force an arrangement under which:
    - **(i) the 2 practitioners share, directly or indirectly, the cost of employing staff, or of buying, renting or maintaining items of equipment; and**
    - (ii) the amounts payable under the arrangement are not fixed at normal commercial rates; or
  - accepts a request from another practitioner to render a diagnostic imaging service where there is in force an arrangement under which:
    - **(i) the 2 practitioners share a particular space in a building; or**
    - (ii) one practitioner provides, directly or indirectly, space in a building for the use or occupation of the other practitioner or permits the other practitioner to use or occupy space in a building; and

(iii) the amounts payable under the arrangement are not fixed at normal commercial rates; or

- stations diagnostic imaging equipment or employees at the premises of another practitioner (whether it is a full-time arrangement or not), so that diagnostic imaging services may be rendered to that practitioner's patients. A practitioner rendering a diagnostic imaging service can apply to Medicare Australia for an exemption from this provision – see below.

- A requesting practitioner (or employer of a requesting practitioner):
- asks, receives or obtains, or agrees to receive or obtain, without reasonable excuse, any property, benefit or advantage of any kind for himself or herself from a "service provider" or a person acting on their behalf.
-

Exemptions from stationing equipment or employees in remote areas.

A practitioner who believes that he or she qualifies for exemption should provide Medicare Australia with a statutory declaration stating the following information:

- the practitioner's full name and provider number;
- physical location where the equipment and/or employee/s will be stationed;
- the need for the exemption;
- the type of equipment;
- the LSPN if available.

DIJ DIAGNOSTIC IMAGING MULTIPLE SERVICES RULES

The multiple services rules apply to all diagnostic imaging services. There are three rules, and more than one rule may apply in a patient episode. The rules do not apply to diagnostic imaging services rendered in a remote area by a medical practitioner who has a remote area exemption for that area - see DID.4.4.

Rule A. When a medical practitioner renders two or more diagnostic imaging services to a patient on the same day, then:

- the diagnostic imaging service with the highest Schedule fee has an unchanged Schedule fee; and
- the Schedule fee for each additional diagnostic imaging service is reduced by $5.

Rule B. When a medical practitioner renders at least one R-type diagnostic imaging service and at least one consultation to a patient on the same day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee as follows:

- if the Schedule fee for the consultation is $40 or more - by $35; or
- if the Schedule fee for the consultation is less than $40 but more than $15 – by $15; or
- if the Schedule fee for the consultation is less than $15 – by the amount of that fee.

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

A 'consultation' is a service rendered under an item from Category 1 of the Medicare Benefits Schedule (MBS), that is, items 1 to 10816 inclusive.

Rule C. When a medical practitioner renders an R-type diagnostic imaging service and at least one non-consultation service to the same patient on the same day, the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $5.

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

For Rule C, a 'non-consultation' is defined as any following item from the MBS:

- Category 2, items 11000 to 12533;
- Category 3, items 13020 to 51318;
- Category 4, items 51700 to 53460;
- Cleft Lip and Palate services, items 75001 to 75854 (as specified in the "Medicare Benefits for the treatment of cleft lip and cleft palate conditions" book.)

Pathology services are not included in Rule C.

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

Multiple Services -Vascular Ultrasound
However, if a medical practitioner provides:

(a) two or more vascular ultrasound services for the same patient on the same day; and
(b) one or more other diagnostic imaging services for that patient on that day

the amount of the fees payable for the vascular ultrasound service is taken, for the purposes of this rule, to be an amount payable for one diagnostic imaging service.

For more information on the Multiple Vascular Ultrasound Services Site Rule - see DIK.6.1

Multiple Services – MRI Musculoskeletal scans

However, if a medical practitioner provides:

(a) two or more MRI services from subgroups 12 and 13 for the same patient on the same day; and
(b) one or more other diagnostic imaging services for that patient on that day

the amount of the fees payable for the MRI services is taken, for the purposes of this rule, to be an amount payable for 1 diagnostic imaging service.
For more information on the MRI MSK Multiple Services Rule – see DIO.6

DIK GROUP I1 - ULTRASOUND

DIK.1 Professional supervision for ultrasound services – R-type eligible services

Ultrasound services (items 55028 to 55854) marked with the symbol *(R)* with the exception of items 55600 and 55603 are not eligible for a Medicare rebate unless the diagnostic imaging procedure is performed under the professional supervision of a:

(a) specialist or a consultant physician in the practice of his or her specialty who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary to personally attend the patient; or

(b) practitioner who is not a specialist or consultant physician who meets the requirements of A or B hereunder, and who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient.

A. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner at the location where the service was rendered and the rendering of those services entitled the payment of Medicare benefits.

B. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner in nursing homes or patients' residences and the rendering of those services entitled payment of Medicare benefits.

If paragraph (a) or (b) cannot be complied with, ultrasound services are eligible for a Medicare rebate:

(i) in an emergency; or
(ii) in a location that is not less than 30 kilometres by the most direct road route from another practice where services that comply with paragraph (a) or (b) are available.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

DIK.2 Sonographer accreditation

Sonographers performing medical ultrasound examinations (either R or NR type items) on behalf of a medical practitioner must be suitably qualified, involved in a relevant and appropriate Continuing Professional Development program and be Registered on the Register of Accredited Sonographers held by Medicare Australia. For further information, please contact the Medicare Australia, Provider Liaison Section, on 132150 for the cost of a local call or the Australasian Sonographer Accreditation Registry on (02) 8850 1144 or through their website at http:/www.asar.com.au

DIK.2.1 Eligibility for registration

In general, to be eligible for registration, the person must:

- hold an accredited postgraduate qualification in medical ultrasound; or
- be studying ultrasound; or
- have worked as a sonographer under the direction of a medical practitioner in Australia or New Zealand (conditions apply - for assessment of eligibility status, please contact the Australasian Sonographer Accreditation Registry).

DIK.2.2 Report requirements

The sonographer's initial and surname is to be written on the report. The name of the sonographer is not required to be included on the copy of the report given to the patient. For the purpose of this rule, the "name" means the sonographer's initial and surname.

DIK.3 Benefits payable

As a rule, benefit is payable **once only** for ultrasonic examination at the **one attendance**, irrespective of the areas involved.

Except as indicated in the succeeding paragraphs, *attendance* means that there is a clear separation between one service and the next. For example, where there is a short time between one ultrasound and the next, benefits will be payable for one service only. As a guide, Medicare Australia will look to a separation of three hours between services and this must be stated on accounts issued for more than one service on the one day.

Where more than one ultrasound service is rendered on the one occasion and the service relates to a non-contiguous body area, and they are "clinically relevant", (ie. the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered), benefits greater than the single rate may be payable. Accounts should be marked "non-contiguous body areas".

Benefits for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning. Accounts should be endorsed "contiguous body area with different set-up requirements".

DIK.4 Subgroup 1 – General

DIK.4.1 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.

DIK.5 Subgroup 2 – Cardiac ultrasound

DIK.5.1 Transoesophageal echocardiography - Item 55135 and consequential amendment to Item 55130

The Medical Services Advisory Committee (MSAC) has 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. Further research will be undertaken to assist MSAC in its future evaluation of the use of intra-operative transoesophageal echocardiography.

DIK.6 Subgroup 3 - Vascular ultrasound

DIK.6.1 Multiple Vascular Ultrasound Services Site Rule (MVUSSR)

A fee discount model applies to vascular ultrasound services. These services must be performed by or on behalf of a medical practitioner.

Where more than one vascular ultrasound service is provided to the same patient by the same practitioner on the same date of service, the following formula applies to the Schedule fee for each service:

- 100% for the item with the greatest Schedule fee
- plus 60% for the item with the next greatest Schedule fee
- plus 50% for each other item.

When the Schedule fee for some of the items are the same, the reduction is calculated in the following order:

- 100% for the item with the greatest Schedule fee and the lowest item number
- plus 60% for the item with the greatest Schedule fee and the second lowest item number
- plus 50% for each other item

When calculating the benefit, it should be noted that despite the reduction, the collective items are treated as one service for the application of the diagnostic imaging multiple services rules (refer DIJ) and the patient gap. Examples can be found on the Medicare Australia website at:
www.medicareaustralia.gov.au/providers/publicationsguidelines/medicalpractitioners.htm

Some restrictions apply to vascular ultrasound items. Medicare benefits are only payable for a maximum of two vascular ultrasound studies in a seven-day period. A vascular ultrasound study may include one or more items. Additionally where a patient is referred for a bilateral study of both arms or both legs (eg both arms for item 55238), the account should indicate 'bilateral' or 'left' and 'right' to enable benefit to be paid.

Medicare benefits are payable for clinically relevant services, that is, the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered. Any decision to have a patient return on a different day to complete a multi-area diagnostic imaging service should only be made on the basis of clinical necessity.

Note: the MVUSSR will apply to all vascular ultrasound items claimed on the same day of service ie whether performed at the same attendance by the same practitioner or at different attendances.

DIK.6.2 Separation of services on the one day/contiguous and non-contiguous body areas

These rules do not apply to the vascular ultrasound items and therefore will not impact on the MVUSSR.

DIK.6.3 Examination of peripheral vessels

Vascular ultrasound services can be claimed in conjunction with item 11612.

DIK.7 Subgroup 4: Urological ultrasound

DIK.7.1 Transrectal ultrasound (Items 55600 and 55603)

Benefits for these items are payable where the service is rendered in the following circumstances:

- a digital rectal examination of the prostate was personally performed by the medical practitioner who also personally rendered the ultrasound service; and
- the transducer probe or probes used meets specifications of normal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz and which can obtain both axial and sagittal scans in 2 planes at right angles; and
- the patient was assessed prior to the service by a medical practitioner recognised in one or more of the specialties specified, not more than 60 days prior to the ultrasound service.

Item 55600 covers the situation where the service was rendered by a medical practitioner who **did not** assess the patient, whereas item 55603 covers the situation where the service was rendered by a medical practitioner who **did** assess the patient.

DIK.8 Subgroup 5: Obstetric and gynaecological ultrasound

DIK.8.1 NR Services

Medicare benefits are not payable for more than three NR-type ultrasound services in Subgroup 5 of Group I1 (ultrasound) that are performed on the same patient in any one pregnancy.

DIK.8.2 Clinical indications

For items where clinical indications are listed (items 55700, 55704, 55718,, 55728, 55759 and 55768), or where a clinical indication is required (items 55712, 55721, 55764 and 55772) for performance of subsequent scans the referral must identify the relevant clinical indication for the service.

It should be noted that a patient must have previously had either a 55706 or 55709 ultrasound in the same pregnancy to be eligible to claim for either a 55712 or 55715 obstetric service. To be eligible to claim for either a 55721 or 55725 obstetric service, a patient must have previously had either a 55718 or 55723 ultrasound in the same pregnancy.

If the service is self-determined (items 55703, 55705, 55715, 55723, 55725, 55762, 55766, 55770 and 55774), the clinical condition or indication must be recorded in the medical practitioner's clinical notes.

DIK.8.3 Nuchal Translucency Testing

Where a nuchal translucency measurement is performed when the pregnancy is dated by a crown rump length of 45-80mm in conjunction with items 55700 (R) or 55703 (NR) or 55704 (R) or 55705 (NR), then items 55707 (R) or 55708 (NR) should be claimed. If nuchal translucency measurement for risk of fetal abnormality is performed in conjunction with any additional condition in items 55700, 55703, 55704 or 55705, only one fee is payable.

It should be noted that the Royal Australian and New Zealand College of Obstet ricians and Gynaecologists (RANZCOG) provides a credentialling program for providers of nuchal translucency scans. It is anticipated that use of items 55707 and 55708 will be restricted to credentialed medical practitioners and sonographers in the future.

DIK.8.4 Multiple pregnancies

Obstetric ultrasound items 55759 to 55774 cover scanning of a patient who is experiencing a multiple pregnancy. The items incorporate a fee adjustment in recognition of the added complexity and costs associated with scanning multiple pregnancies. Based on the recommendations of the profession, the items apply only to patients where a multiple pregnancy has been confirmed by ultrasound. The items include identical restrictions and provisions as the second and third trimester items (55706-55725), and include items for referred and non-referred services.

DIK.8.5 Ultrasound scan of pelvis or abdomen, pregnancy related – Item 55728

This item should only be claimed in situations where a patient with a clinical condition not listed in items 55718, 55721, 55723 and 55725 requires a post 22 week ultrasound. Claims for this item are required to be assessed by the Health Insurance Commission on an individual basis and should be accompanied by details of the clinical basis for the service. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked 'Medical-in Confidence' (See 8.6 of the General Explanatory Notes).

DIK.8.6 Obstetric ultrasound and non-metropolitan providers (Items 55712, 55721 55728 55764 and 55772)

Where a practitioner has obstetric privileges at a non-metropolitan hospital and refers for items 55712, 55721 and 55728, 55764 and 55772, the practitioner must confirm his/her eligibility by stating 'non-metropolitan obstetric privileges' on the referral form.

In relation to items 55712, 55721, 55728, 55764 and 55772, non-metropolitan area includes any location outside of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 1999 published by the Australian Bureau of Statistics (publication number 1216.0 of 1999.

DIK.9 Subgroup 6: Musculoskeletal ultrasound

DIK.9.1 Personal attendance

Medicare Benefits are only payable for a musculoskeletal ultrasound service (items 55800 to 55854) if the medical practitioner responsible for the conduct and report of the examination personally attends during the performance of the scan and personally examines the patient. Services that are performed because of medical necessity in a remote location are exempt from this requirement – see DID.4.4 for definition of remote area. Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

DIK.9.2 Equipment

Items 55800 to 55854 only apply to an ultrasound service performed using an ultrasound system which has available on-site a transducer capable of operation at, at least 7.5 megahertz.

DIK.9.3 Single rebate per day

Items 55800 to 55854 apply once a day for each patient regardless of the number of regions scanned in performing the service/s.

DIK.9.4 Comparison musculoskeletal ultrasound

Where it is necessary for one or more views of the opposite limb to be taken for comparison purposes, benefits are payable for the sonographic examination and reporting of one limb only. Comparison views are considered to be part of the examination requested.

DIK.9.5 Shoulder and knee (Items 55808 and 55810 and 55828 and 55830)

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

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

- meniscal and cruciate ligament tears; and
- assessment of chondral surfaces.

DIL GROUP I2: COMPUTED TOMOGRAPHY (CT)

DIL.1 Capital sensitive items

A reduced Schedule fee applies to CT services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago. A range of items cover services provided on older equipment. These items are:

56041, 56047, 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56141, 56147, 56259, 56341, 56347, 56441, 56447, 56449, 56452, 56541, 56547, 56659, 56665, 56841, 56847, 57041, 57047, 57247, 57345, 57355.

These items are identified by the addition of the letter '(NK)' at the end of the item. These items should be used where services are performed on equipment ten years old or older, except where equipment is located in a remote area when items with the letter "K", as described below, will apply – see DID.4.4 for definition of remote area.

Items 56001 to 57356 (which contain the symbol (K) at the end of the item should be used for services which are performed on a date which is less than ten years after the date on which the CT equipment used in performing the service was first installed in Australia. In the case of imported pre-used CT equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

For the purposes of capital sensitive items CT equipment includes the following components:
(a) a gantry;
(b) a couch;

(c) a computer; and
(d) an operator station.

DIL.2 Professional supervision

CT services (items 56001 to 57356) are not eligible for a Medicare rebate unless the service is performed:

(a) under the professional supervision of a specialist in the specialty of diagnostic radiology who is available:
  (i) to monitor and influence the conduct and diagnostic quality of the examination; and
  (ii) if necessary, to personally attend on the patient; or
(b) if paragraph (a) cannot be complied with
  (i) in an emergency, or
  (ii) because of medical necessity in a remote area – refer to DID.4.4 for definition of remote area.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

DIL.3 CT service where PET scan is performed

Medicare benefits are not payable for any CT scans rendered using a Hybrid Positron Emission Tomography/Computed Tomography (PET/CT) scanner.

DIL.4 Scan of more than one area

Items have been provided to cover the common combinations of regions - see DIL.5. However, where regions are scanned on the one occasion which are not covered by a combination item, for example, item 57001 (scan of brain) and item 56619 (scan of extremities), both examinations would attract separate benefit.

DIL.5 CT scans of multiple regions

Items have been provided to cover the common combinations of regions. The items relating to the individual contiguous regions should not be used when scans of multiple regions are performed.

DIL.6 More than one attendance of the patient to complete a scan

Items 56220 to 56240 and 56619 to 56665 apply once only for a service described in any of those items, regardless of the number of patient attendances required to complete the service. For example, where a request relates to two or more regions of the spine and one region only is scanned on one occasion with the balance of regions being scanned on a subsequent occasion, benefits are payable for one combination service only upon completion.

DIL.7 Pre contrast scans

Pre contrast scans are included in an item of service with contrast medium only when the pre-contrast scans are of the same region.

DIL.8 CT Head

DIL.8.1 Exclusion of acoustic neuroma

If an axial scan is performed for the exclusion of acoustic neuroma, Medicare benefits are payable under item 56001 or 56007.

DIL.8.2 Assessment of headache

If the service described in item 56007 or 56047 is used for the assessment of headache of a patient, the fee mentioned in the item applies only if:
(a) a scan without intravenous contrast medium has been undertaken on the patient; and
(b) the service is required because the result of the scan is abnormal.

This rule applies to a patient who:
(i) is under 50 years; and
(ii) is (apart from the headache) otherwise well; and
(iii) has no localising symptoms or signs; and
(iv) has no history of malignancy or immunosuppression.

DIL.9 CT Spine

CT items exist which separate the examination of the spine into the cervical, thoracic and lumbosacral regions. These items are 56220 to 56240 inclusive. They include items for CT scans of two regions of the spine (56233, 56234, 56235 and 56236) and for all three regions of the spine (56237, 56238, 56239 and 56240). Restrictions apply to the following items:

(a) item 56233 is used where two examinations of the kind referred to in items 56220, 56221 and 56223 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.
(b) item 56234 is used where two examinations of the kind referred to in items 56224, 56225 and 56226 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.
(c) item 56235 is used where two examinations of the kind referred to in items 56227, 56228 and 56229 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed
(d) item 56236 is used where two examinations of the kind referred to in items 56230, 56231 and 56232 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed

Example: for a CT examination of the spine where the cervical and thoracic regions are to be studied (item 56233), item numbers 56220 and 56221 must be specified.

DIL.9.1 With intrathecal contrast medium (Item 56219)

The item incorporates the cost of contrast medium for intrathecal injection and associated x-rays. Benefits are not payable for this item when rendered in association with myelograms (Item 59724). Where a myelogram is rendered under item 59724 and a CT is necessary, the relevant item would be scan of spine without intravenous contrast (Item 56220, 56221 or 56223).

DIL.10 Upper abdomen and Pelvis

Items 56501, 56507, 56541 and 56547 are not eligible for Medicare Benefits if performed for the purpose of performing a virtual colonoscopy (otherwise known as CT colonography and CT colography).

Items 56549 and 56551 have been included in the Medicare Benefits Schedule (MBS) for a limited period of two years and pending the outcome of an assessment of the procedure by the Medical Services Advisory Committee (MSAC). For audit purposes, an incomplete colonoscopy is defined as one that is not completed for technical or medical reasons and must have been performed in the preceding 3 months.

DIL.11 Spiral angiography

DIL.11.1 Items 57350 and 57355 and items 57351 and 57356

CT spiral angiography items 57351 and 57356 apply under certain circumstances specified in the items including where a service to which items 57350 or 57355 have been performed on the same patient within the previous 12 months, whereas items 57350 and 57355 apply under the circumstances specified in the items and where the service has **not** been performed on the same patient within the previous 12 months.

DIM GROUP I3: DIAGNOSTIC RADIOLOGY

DIM.1 Examination and report

As for all diagnostic imaging services, the benefits allocated to each item from 57506 to 60509 inclusive cover the total service, ie. the image, reading and report. Separate benefits are not payable for individual components of the service, eg preliminary reading. Benefits are not separately payable for associated plain films involved with these items.

DIM.2 Exposure of more than one film

Where the radiographic examination of a specific area involves the exposure of more than one film, benefits are payable once only, except where special provision is made in the description of the item for the inclusion of all films taken for the purpose of the examination. This means that if a x-ray of the foot is requested, regardless of the number of exposures from different angles, the completed service comprises x-ray of the foot by one or more exposures and the report. The exception to this

would be the plain x-ray of the spine items (58100 to 58115) where the item number differs dependent upon the regions of the spine that are examined at the same occasion, ie. 58112 applies where two regions are examined.

DIM.3 Comparison X-rays

Where it is necessary for one or more films of the opposite limb to be taken for comparison purposes, benefits are payable for radiographic examination and reporting of one limb only. Comparison views are considered to be part of the examination requested.

DIM.4 Subgroup 4: Radiographic examination of the spine

DIM.4.1 Multiple regions

Multiple region items require that the regions of the spine to be studied must be specified on any account issued or patient assignment form completed.

Where item 58112 is rendered (spine, two regions), the item numbers for the regions of the spine being studied must be specified (ie from items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical and thoracic regions are to be studied, item numbers 58100 and 58103 must be specified on any account issued or patient assignment forms completed.

Where item 58115 is rendered (spine, three regions), the item numbers for the regions of the spine being studied must be specified (items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical, the thoracic and the lumbosacral regions are to be studied, item numbers 58100, 58103 and 58106 must be specified on any accounts issued or patient assignment forms completed.

Hand and wrist combination X-ray

An examination of the hand and the wrist on the same side should be claimed as item 57512 (NR) or 57515 (R). If items 57506 (NR) or 57509 (R) are claimed for multiple non-adjacent areas on the same side, or areas on different sides, the account should include annotation on this eg L and R hand, hand and humerus.

DIM.5 Subgroup 8: Radiographic examination of alimentary tract and biliary system

DIM.5.1 Plain abdominal film (Items 58900/58903)

Benefits are not attracted for Items 58900/58903 in association with barium meal examinations or cholecystograms whether provided on the same day or previous day. Preliminary plain films are covered in each study.

DIM.6 Subgroup 10: Radiographic examination of the breasts

DIM.6.1 Items 59300 and 59303

Benefits under items 59300 and 59303 are attracted only where the patient has been referred in specific circumstances as indicated in the description of the items. To facilitate these provisions, the requesting medical practitioner is required to include in the request the clinical indication for the procedure. The requesting practitioner must personally sign the request.

The reference to “with or without thermography” has been removed from the item descriptor for items 59300 and 59303 with effect from 1 November 2003. The Radiology Management Committee (RMC) at its meeting of 12 August 2003, agreed that there is no current scientific evidence to support the use of thermography in the early detection of breast cancer and in the reduction of mortality.

DIM.6.2 Professional supervision

Mammography services (items 59300 to 59318) are not eligible for a Medicare rebate unless the diagnostic imaging procedure is performed under the professional supervision of a:

(a) specialist in the specialty of diagnostic radiology who is available to monitor and influence the conduct and diagnostic quality of the examination, and, if necessary, to personally attend on the patient; or
(b) if paragraph (a) cannot be complied with:
  (i) in an emergency; or
  (ii) because of medical necessity in a remote location.
  Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

DIM.7 Subgroup 12: Radiographic examination with opaque or contrast media

DIM.7.1 Myelogram (Item 59724)

Benefits are not payable where a myelogram is rendered in association with a CT myelogram (Item 56219 - see DIL.9.1). Where it is necessary to render a CT and a myelogram, CT Items 56220, 56221 and 56223 would apply.

DIM.8 Subgroup 13: Angiography

DIM.8.1 Angiography services - meaning of (K) and (NK)

A reduced Schedule fees applies to cardiac angiography services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago.

A range of items cover services provided on older equipment. These items are 59971, 59972, 59973 and 59974, are identified by the addition of the letters '(NK)' at the end of the item and should be used where services are performed on equipment ten years old or older.

Items 59903, 59912, 59925 and 59970 have the letter '(K)' included at the end of the item. These items should be used where services are performed on equipment first installed in Australia less than ten years ago. In the case of imported pre-used equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

DIM.8.2 Digital subtraction angiography (DSA) (Items 60000-60078)

Benefits are payable only where these services are rendered in an angiography suite (a room that contains only equipment designed for angiography that is able to perform digital subtraction or rapid-sequence film angiography). Benefits are not payable when these services are rendered using mobile DSA imaging equipment as these services are covered by item 59970.

Each item includes all preparation and contrast injections other than for selective catheterisation. For Digital Subtraction Angiography (DSA), benefits are payable for a maximum of 1 DSA item (from Items 60000 to 60069). For selective DSA - 1 DSA item (from Items 60000 to 60069) and 1 item covering selective catheterisation (from 60072, 60075 or 60078).

If a DSA examination covers more than one of the specified regions/combinations, then the region/combination forming the major part of the examination should be selected, with itemisation to cover the total number of film runs obtained. A run is the injection of contrast, data acquisition, and the generation of a hard copy record.

DIM.9 Subgroup 16: Preparation for radiological procedure

DIM.9.1 Preparation items (Items 60918 and 60927)

Items 60918 and 60927 apply only to the preparation of a patient for a radiological procedure for a service to which any of items 59903 to 59974 apply. A report is not required for these services.

DIN GROUP I4 - NUCLEAR MEDICINE IMAGING

DIN.1 General

Benefits for a nuclear scanning service are only payable when the service is performed by a specialist or consultant physician, or by a person acting on behalf of the specialist and the final report of the service is compiled by the specialist or consultant physician who performed the preliminary examination of the patient and the estimation and administration of the dosage.

Additional benefits will only be attracted for specialist physician or consultant physician attendance under Category 1 of the Schedule where there is a request for a full medical examination accompanied by a referral letter or note of referral.

DIN.2 Credentialling for nuclear medicine imaging services

Payment of Medicare rebates for nuclear medicine imaging services is limited to specialists or consultant physicians who are credentialled by the Joint Nuclear Medicine Credentialling and Accreditation Committee of the Royal Australian College of Physicians (RACP) and the Royal Australian and New Zealand College of Radiologists (RANZCR). The scheme has been developed by the profession in consultation with Government to ensure that specialists in nuclear medicine are appropriately trained and licensed, provide appropriate personal supervision of procedures and are involved in ongoing continuing medical education.

For information regarding the Scheme and for application forms, please phone the RACP or RANZCR.

DIN.3 Radiopharmaceuticals

The Schedule fees for nuclear medicine imaging services incorporate the costs of radiopharmaceuticals.

DIN.4 Single Photon Emission Computed Tomography (SPECT)

Where SPECT has been performed in conjunction with another study and is not covered under the item descriptor or is not covered under Item 61462, no Medicare benefit is payable for the SPECT study.

DIN.5 Single myocardialperfusion studies (Items 61302 and 61303)

Items 61302 and 61303 apply to single myocardial perfusion studies which can only be used once and cannot be used in conjunction with any other myocardial perfusion study for an individual patient referral.

DIN.6 Myocardialperfusion (Items 61306 and 61307)

Items 61306 and 61307 refer to all myocardial perfusion studies involving two or more sets of imaging times related to an individual patient referral. This includes stress/rest, stress/re-injection, stress/rest and re-injection thallium studies, one or two-day technetium-based perfusion agent protocols, mixed technetium-based perfusion agent/thallium protocols and the use of gated SPECT when undertaken.

DIN.7 Hepatobiliary study (pre-treatment) (Item 61360)

Item 61360 - the standard hepatobiliary item - also includes allowance of the pre-procedural CCK administration for preparatory emptying of the gall bladder and also morphine augmentation.

DIN.8 Hepatobiliary study (infusion) (Item 61361)

Item 61361 applies specifically to a standard hepatobiliary study to which has been added an infusion of sinaclide (CCK-8) following which acquisition is continued and quantification of gallbladder ejection fraction and/or common bile duct activity time curves are performed.

DIN.9 Whole body studies (Items 61426-61438)

"Whole body" studies must include the trunk, head and upper and lower limbs down to the elbow and knee joints respectively, whether acquired as multiple overlapping camera views or whole body sweeps (runs) with additional camera views as required. Any study that does not fulfil these criteria is a localised study.

DIN.10 Repeat studies (Item 61462)

Item 61462 covers repeat planar (whole body or localised) and/or SPECT imaging performed on a separate occasion using the same administration of radiopharmaceutical. The repeat planar and SPECT imaging when performed on a separate occasion using the same administration of radiopharmaceutical should be itemised as item 61462 and the original item and date of service should be indicated for reference purposes.

This item does not apply to bone scans, adrenal studies or gastro-oesophageal reflux studies, myocardial perfusion studies, colonic transit or CFS transport studies, where allowance for performance of the delayed study is incorporated into the baseline benefit fee.

DIN.11 Thyroid study (Item 61473)

Item 61473 incorporates the measurement of thyroid uptake on a gamma camera using a proven technique, where clinically indicated.

DIO GROUP I5: MAGNETIC RESONANCE IMAGING (MRI)

DIO.1 Itemisation

MRI items in Group I5, items 63001 to 63497, are divided into subgroups defined according to the area of the body to be scanned, (ie head, spine, musculoskeletal system, cardiovascular system or body) and the number of occasions in a defined period in which Medicare benefits may be claimed by a patient. Subgroups are divided into individual items, with each item being for a specific clinical indication.

DIO.2 Eligible services

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

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

DIO.3 Requests

A referral must be in writing and identify the clinical indications for the service.

MRI services can only be requested by a recognised specialist medical practitioner or consultant physician for the purpose of the *Health Insurance Act* 1973. However, there are exceptions to this provision for a limited number of MRI:

- All dental specialists, prosthodontists, oral and maxillofacial surgeons, oral medicine specialists and oral pathology specialists may request item 63334 – scan of musculoskeletal system for derangement of the temporomandibular joint (s).
- Oral and maxillofacial surgeons and oral medicine and oral pathology specialists can also request item 63007 – scan of the head for skull base or orbital tumour.

DIO.4 Professional supervision

Group I5 items must be performed as follows:

(a) under the professional supervision of an eligible provider who is available to monitor and influence the conduct and diagnostic quality of the examination, including, if necessary, by personal attendance on the patient; or
(b) if paragraph (a) is not complied with:
    (i) in an emergency; or
    (ii) because of medical necessity, in a remote location (refer to DID.4.4).

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

DIO.5 Eligible providers

In Group I5, an eligible provider is a specialist in diagnostic radiology who satisfies Medicare Australia that:

(a) he or she is a participant of the Royal Australian and New Zealand College of Radiologists' (RANZCR) Quality and Accreditation Program; and
(b) the equipment he or she proposes to use for providing services of the kind mentioned in Group I5 is eligible equipment.

DIO.5.1 Eligible Provider declaration

The specialist must give Medicare Australia a statutory declaration:

(a) stating that he or she is enrolled in the RANZCR Quality and Accreditation Program;
(b) specifying the location of the MRI equipment;

(c) specifying the kinds of diagnostic imaging equipment offered at the that location;
(d) stating the date of installation of the equipment (and the time of installation if this occurred on 12 May 1998); and
(e) if the equipment had not been installed before 7.30pm on 12 May 1998 (Eastern Standard Time), the specialist must also give Medicare Australia a copy of the contract for the purchase or lease of the equipment.

In addition Medicare Australia may request further supporting documentation or information. Specialists or consultant physicians are advised to contact the Provider Liaison Section, Medicare Australia on 132 150 prior to lodging a declaration.

DIO.6 Eligible equipment

Eligible equipment is equipment which is:

(a) equipment within the meaning of rule 31 of Part 2 of Schedule 1 to the Health Insurance (Diagnostic Imaging Services Table) Regulations 2000, as in force on 31 October 2001; or
(b) equipment that is registered under the scheme, administered by the Department, titled 'MRI Additional Units Eligibility Scheme', as in force on 27 June 2001, and in relation to which registration has not been cancelled or otherwise ceased to have effect; or
(c) equipment that is registered under the scheme, administered by the Department, titled '2004 MRI Additional Units Eligibility Scheme', as in force on 29 November 2004; or
(d) equipment located in a children's hospital described in rule 36(c) – *eligible equipment*, of the Health Insurance (Diagnostic Imaging Services Table) Regulations as in force on 1 November 2005.

DIO.7 Number of eligible services

Items have been placed in subgroups according to frequency restrictions for Medicare eligibility as follows:

- Services in subgroups 1, 4, 6, 8, 11 and 18 have no frequency restriction.
- Services in subgroups 16 and 19 may be claimed on one occasion in any 12-month period.
- Services in subgroups 13, 14 and 17 may be claimed on two occasions in any 12-month period.
- Services in subgroups 2, 3, 5, 7, 9, 10, 12 and 15 may be claimed on three occasions in any 12-month period.
- Services in subgroup 20 may be claimed only once in a patient's lifetime.
- Items in subgroup 21 may only be ordered in conjunction with an eligible MRI/MRA service (see DIO.10).

Example : Item 63271 in subgroup 10 can be claimed by a patient on three occasions in any 12 month period. If the patient had claimed Medicare benefits for the following:

Item	Date of service
63271	10/12/04
63271	18/4/05
63271	16/10/05
63271	11/12/05

The following table demonstrates which dates of service would be eligible:

Date of service	Claimable?	Why?
12/3/05	No	Between 10/12/04 and 9/12/05, the patient would have had 4 x 63271 in 12 months - 10/12/04, 12/3/05, 18/4/05 and 16/10/05
4/3/06	No	Between 5/3/05 and 4/3/06, the patient would have had 4 x 63271 in 12 months - 18/4/05, 16/10/05, 11/12/05 and 4/3/06
20/4/06	Yes	Between 21/4/05 and 20/4/06, the patient would have had 3x 63271 in 12 months - 16/10/05, 11/12/05 and 20/4/06

The frequency restrictions are therefore considered to be rolling restrictions and not based on calendar or financial years.

In addition, restrictions on the number of services of the kind described in subgroup 12 apply to specific anatomical sites. Where an item description applies to more than one anatomical site the restriction on the number of services applies to each site.

- Item 63328, MRI scan for derangement of the knee or its supporting structures, applies to two specific anatomical sites, ie, right knee and left knee. Each anatomical site may be scanned up to 3 times in any 12-month period.

DIO.8 MRI Musculoskeletal (MSK) Multiple Services

If a medical practitioner performs 2 or more scans from subgroup 12 and 13 for the same patient on the same day, the fees specified for items that apply to the service are affected as follows:

(a) the item with the highest schedule fee retains 100% of the schedule fee; and
(b) any other fee, except the highest is reduced by 50%.

However, if 2 or more applicable fees are equally the highest, only one of those fees is taken to be the highest fee. If this occurs, the other fee, or another fee, is taken to be the second highest fee.

If the reduced fee is not a multiple of 5 cents, the reduced fee is taken to be the nearest amount that is a multiple of 5 cents.

In addition, the modifying item for contrast may only be claimed once for a group of services subject to this rule.

DIO.9 Restrictions between MRI/MRA

When services in subgroups 1, 2, 4, 5 and 14 (MRI of the Head, Head and Cervical Spine or Cardiovascular system) and services from subgroups 3 and 15 (Magnetic Resonance Angiography) are performed on a single occasion, only the MRI rebate is claimable.

Example: Service 63064, MRI scan of head for stroke, is performed on the same occasion as service 63401, MRA scan for vascular abnormality. In this circumstance only item 63064 may be claimed.

DIO.10 Subgroup 21 -Modifying Items

Subgroup 21 contains a number of items which modify the value of the MRI/MRA service claimed for the additional cost or complexity of performing a service on a patient who is sedated, under a general anaesthetic or is undergoing a service requiring the use of contrast. These items may only be claimed in conjunction with an eligible MRI/MRA service.

The modifying items are not considered to be services for the diagnostic imaging multiple services rules.

DIO.10.1 Contrast

- Services eligible for use with contrast are denoted by (Contrast).
- If more than one service is completed in which contrast is used, item 63491 may be claimed for each eligible service, except where restricted by another rule (see DIO.3.3).

DIO.10.2 Anaesthetic and Sedation

- The anaesthetic modifier is for use by the eligible provider performing the scan, not the Anaesthetist. Medicare benefits for Anaesthesia services are payable under Category 3 (Therapeutic Procedures), section T10 (Relative Value Guide), of the 1 November 2003 Medicare Benefits Schedule. The minimum requirements for anaesthesia (including sedation) are listed in section T10.5 of the explanatory notes in section T10.
- The modifiers for sedation and anaesthetic may not be claimed together, if a patient is both sedated and anaesthetised only the anaesthetic modifier should be claimed.
  If more than one scan is provided on a single occasion in which sedation or anaesthetic is used, either item 63494 or 63497 may only be claimed on the first scan.

DIP. MANAGEMENT OF BULK-BILLED SERVICES

DIP.1 Additional bulk billing payment for diagnostic imaging services (item 64990 and 64991)

Item 64990 operates in the same way as item 10990 and item 64991 operates in the same way as item 10991 (see explanatory note M.1 of the General Medical services notes), apart from the following differences:

- Item 64990 and 64991 can only be used in conjunction with items in the Diagnostic Imaging Services Table of the MBS;
- Item 64990 and 64991 applies to diagnostic imaging services self determined by general practitioners and specialists with dual qualifications acting in their capacity as general practitioners;
- Specialists and consultant physicians who provide diagnostic imaging services are not able to claim

item 64990 or 64991 unless, for the purposes of the *Health Insurance Act 1973*, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to that practitioner by another medical practitioner or person with referring rights.

GROUP I1 - ULTRASOUND

SUBGROUP 1 - GENERAL

55028	HEAD, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIK. of explanatory notes to this Category)*	**Benefit:** 75% ~~=~~$81.85	85% ~~=~~$92.75
55029	HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIK. of explanatory notes to this Category)*	**Benefit:** 75% ~~=~~$28.40	85% ~~=~~$32.20
55030	ORBITAL CONTENTS, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIK. of explanatory notes to this Category)*	**Benefit:** 75% ~~=~~$81.85	85% ~~=~~$92.75
55031	ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIK. of explanatory notes to this Category)*	**Benefit:** 75% ~~=~~$28.40	85% ~~=~~$32.20
55032	NECK, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIK. of explanatory notes to this Category)*	**Benefit:** 75% ~~=~~$81.85	85% ~~=~~$92.75
55033	NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIK. of explanatory notes to this Category)*	**Benefit:** 75% ~~=~~$28.40	85% ~~=~~$32.20
55036	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55038, 55044 or 55731 on the same patient within 24 hours (R) *(See para DIK. of explanatory notes to this Category)*	**Benefit:** 75% ~~=~~$83.50	85% ~~=~~$94.65
55037	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIK. of explanatory notes to this Category)*	**Benefit:** 75% ~~=~~$28.40	85% ~~=~~$32.20

55038	URINARY TRACT, ultrasound scan of but not being a service associated with the service described in item 55600 or item 55603, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55036, 55044 or 55731 on the same patient within 24 hours (R) *(See para DIK. of explanatory notes to this Category)* **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55039	URINARY TRACT, ultrasound scan of, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIK. of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55044	PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R) *(See para DIK. of explanatory notes to this Category)* **Fee:** $111.30	**Benefit:** 75% = $83.50	85% = $94.65
55045	PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIK. of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55048	SCROTUM, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIK. of explanatory notes to this Category)* **Fee:** $109.50	**Benefit:** 75% = $82.15	85% = $93.10
55049	SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIK. of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55054	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) *(See para DIK. of explanatory notes to this Category)* **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55070	BREAST, one, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $98.25	**Benefit:** 75% = $73.70	85% = $83.55
55073	BREAST, one, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) **Fee:** $34.05	**Benefit:** 75% = $25.55	85% = $28.95

55076	BREASTS, both, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55079	BREASTS, both, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
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:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55
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:** $34.05 **Benefit:** 75% = $25.55 85% = $28.95
	SUBGROUP 2 - CARDIAC
55113	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (R) **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55114	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (R) **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55115	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of congenital heart disease (R) **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55116	EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) **Fee:** $256.50 **Benefit:** 75% = $192.40 85% = $218.05
55117	PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) **Fee:** $256.50 **Benefit:** 75% = $192.40 85% = $218.05

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
	SUBGROUP 3 - VASCULAR
55238	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55244	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55246	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55248	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb OR of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55252	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55274	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55276	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins OR of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55278	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels OR of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10

55280	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) **Fee:** $169.50	**Benefit:** 75% =$127.15	85% =$144.10
55282	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) **Fee:** $169.50	**Benefit:** 75% =$127.15	85% =$144.10
55284	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R) **Fee:** $169.50	**Benefit:** 75% =$127.15	85% =$144.10
55292	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (R) **Fee:** $169.50	**Benefit:** 75% =$127.15	85% =$144.10
55294	DUPLEX SCANNING, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins OR arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), 3 or 4 of this Group applies - including any associated skin marking (R) **Fee:** $169.50	**Benefit:** 75% =$127.15	85% =$144.10
55296	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), 3 or 4 of this Group applies - including any associated skin marking (R) **Fee:** $111.05	**Benefit:** 75% =$83.30	85% =$94.40
	SUBGROUP 4 - UROLOGICAL		
55600	PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in (c)) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days prior to the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R) **Fee:** $109.10	**Benefit:** 75% =$81.85	85% =$92.75

	PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed: (a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days prior to the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R)
55603	**Fee:** $109.10 **Benefit:** 75% =$81.85 85% =$92.75
	SUBGROUP 5 - OBSTETRIC AND GYNAECOLOGICAL
	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R)
I 55700	Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 80mm, refer to item number 55707 (R). Fee is payable only for item 55700 or item 55707, not both items. **Fee:** $60.00 **Benefit:** 75% =$45.00 85% =$51.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) one or more of the following conditions are present:
- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (NR)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 80mm, refer to item number 55708 (R). Fee is payable only for item 55703 or item 55707, not both items.

I 55703 **Fee:** $35.00 **Benefit:** 75% =$26.25 85% =$29.75

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:

(a) the patient is referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) one or more of the following conditions are present:

- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (R)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 80mm, refer to item number 55707 (R). Fee is payable only for item 55704 or item 55707, not both items.

I 55704 **Fee:** $70.00 **Benefit:** 75% ~~=~~$52.50 85% ~~=~~$59.50

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) one or more of the following conditions are present:
- (i) hyperemesis gravidarum
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (NR)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 80mm, refer to item number 55708 (R). Fee is payable only for item 55705 or item 55708, not both items.

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55705 **Fee:** $35.00 **Benefit:** 75% =$26.25 85% =$29.75

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:

(a) the patient is referred by a medical practitioner; and
(b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and
(e) the service is not performed in the same pregnancy as item 55709 (R)

55706 **Fee:** $100.00 **Benefit:** 75% =$75.00 85% =$85.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where;

(a) the patient is referred by a medical practitioner; and
(b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 80mm; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and
(e) one or more of the conditions mentioned in subparagraphs (e) (i) to (xxx) of item 55704 are present; and
(f) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and
(g) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (R)

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(See para DIK. of explanatory notes to this Category)
55707 **Fee:** $70.00 **Benefit:** 75% =$52.50 85% =$59.50

H 55708	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is not referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 80mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 are present; and (e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (f) the service is not performed in conjunction with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (NR) *(See para DIK. of explanatory notes to this Category)* **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
55709	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55706 (NR) **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30
55712	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologi sts as being equivalent to a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (R) *(See para DIK. of explanatory notes to this Category)* **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75
55715	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (NR) **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:

(a) the patient is referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) the service is not performed in the same pregnancy as item 55723; and

(f) one or more of the following conditions are present:

- (i) known or suspected fetal abnormality or fetal cardiac arrhythmia;
- (ii) fetal anatomy (late booking or incomplete mid-trimester scan);
- (iii) malpresentation;
- (iv) cervical assessment;
- (v) clinical suspicion of amniotic fluid abnormality;
- (vi) clinical suspicion of placental or umbilical cord abnormality;
- (vii) previous complicated delivery;
- (viii) uterine scar assessment;
- (ix) uterine fibroid;
- (x) previous fetal death in utero or neonatal death;
- (xi) antepartum haemorrhage;
- (xii) clinical suspicion of intrauterine growth retardation;
- (xiii) clinical suspicion of macrosomia;
- (xiv) reduced fetal movements;
- (xv) suspected fetal death;
- (xvi) abnormal cardiotocography;
- (xvii) prolonged pregnancy;
- (xviii) premature labour;
- (xix) fetal infection;
- (xx) pregnancy after assisted reproduction;
- (xxi) trauma;
- (xxii) diabetes mellitus;
- (xxiii) hypertension;
- (xxiv) toxaemia of pregnancy;
- (xxv) liver or renal disease;
- (xxvi) autoimmune disease;
- (xxvii) cardiac disease;
- (xxviii) alloimmunisation;
- (xxix) maternal infection;
- (xxx) inflammatory bowel disease;
- (xxxi) bowel stoma;
- (xxxii) abdominal wall scarring;
- (xxxiii) previous spinal or pelvic trauma or disease;
- (xxxiv) drug dependency;
- (xxxv) thrombophilia;
- (xxxvi) significant maternal obesity;
- (xxxvii) advanced maternal age;
- (xxxviii) abdominal pain or mass (R)

55718 **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where:

(a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obster icians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R)

(See para DIK. of explanatory notes to this Category)

55721 **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75

55723	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55718; and (e) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (NR) **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30
55725	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricans and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (NR) **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00

	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) it can be demonstrated that a clinical condition other than a condition mentioned in paragraph (f) of item 55718 or paragraph (e) of item 55723 is present (R) *(See para DIK. of explanatory notes to this Category)*		
55728	**Fee:** $100.00	**Benefit:** 75% = $75.00	85% = $85.00
	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies - (R)		
55729	**Fee:** $27.25	**Benefit:** 75% = $20.45	85% = $23.20
	PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R)		
55731	**Fee:** $98.00	**Benefit:** 75% = $73.50	85% = $83.30
	PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR)		
55733	**Fee:** $35.00	**Benefit:** 75% = $26.25	85% = $29.75
	PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R)		
55736	**Fee:** $127.00	**Benefit:** 75% = $95.25	85% = $107.95
	PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR)		
55739	**Fee:** $57.00	**Benefit:** 75% = $42.75	85% = $48.45
	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55762 during the same pregnancy (R)		
55759	**Fee:** $150.00	**Benefit:** 75% = $112.50	85% = $127.50

55762	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55759during the same pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR) **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00
55764	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obster icians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759 or 55762 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (R) **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00
55766	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, or 55762 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (NR) **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
55768	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723, 55725 or 55728 during the same pregnancy (R) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
55770	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55723, 55725 or 55728 during the same pregnancy (NR) **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00

55772	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723, 55725 or 55728 during the same pregnancy (R) **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00
55774	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed ;and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721 55723, 55725 or 55728 during the same pregnancy (NR) **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
	SUBGROUP 6 - MUSCULOSKELETAL
55800	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55802	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55804	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55806	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55808	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone*. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(R) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75

	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone*. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(NR)
55810	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)
55812	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR)
55814	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)
55816	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies: and (b) the patient is not referred by a medical practitioner (NR)
55818	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)
55820	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR)
55822	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)
55824	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR)
55826	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20

55828	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(R) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55830	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(NR) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55832	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55834	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55836	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the services is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55838	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55840	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55842	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55844	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $87.35 **Benefit:** 75% = $65.55 85% = $74.25

55846	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55848	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 (R) **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55850	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55054, or 55800 to 55848, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $152.85	**Benefit:** 75% = $114.65	85% = $129.95
55852	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the patient is referred by a medical practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55854	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (NR) **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20

GROUP I2 - COMPUTED TOMOGRAPHY

HEAD

56001	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (K) (Anaes.) **Fee:** $195.05	**Benefit:** 75% = $146.30	85% = $165.80
56007	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57007 applies (R) (K) (Anaes.) **Fee:** $250.00	**Benefit:** 75% = $187.50	85% = $212.50
56010	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) **Fee:** $252.10	**Benefit:** 75% = $189.10	85% = $214.30
56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) **Fee:** $250.00	**Benefit:** 75% = $187.50	85% = $212.50
56016	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) (Anaes.) **Fee:** $290.00	**Benefit:** 75% = $217.50	85% = $246.50
56022	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) (Anaes.) **Fee:** $225.00	**Benefit:** 75% = $168.75	85% = $191.25
56028	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (K) (Anaes.) **Fee:** $336.80	**Benefit:** 75% = $252.60	85% = $286.30
56030	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) (Anaes.) **Fee:** $225.00	**Benefit:** 75% = $168.75	85% = $191.25
56036	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K) (Anaes.) **Fee:** $336.80	**Benefit:** 75% = $252.60	85% = $286.30
56041	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) (Anaes.) **Fee:** $98.75	**Benefit:** 75% = $74.10	85% = $83.95
56047	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57047 applies (R) (NK) (Anaes.) **Fee:** $126.10	**Benefit:** 75% = $94.60	85% = $107.20
56050	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) **Fee:** $128.20	**Benefit:** 75% = $96.15	85% = $109.00
56053	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) **Fee:** $128.20	**Benefit:** 75% = $96.15	85% = $109.00
56056	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) (Anaes.) **Fee:** $155.45	**Benefit:** 75% = $116.60	85% = $132.15
56062	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) (Anaes.) **Fee:** $113.15	**Benefit:** 75% = $84.90	85% = $96.20

56068	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (NK) (Anaes.) **Fee:** $168.40 **Benefit:** 75% = $126.30 85% = $143.15
56070	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) (Anaes.) **Fee:** $113.15 **Benefit:** 75% = $84.90 85% = $96.20
56076	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) (Anaes.) **Fee:** $168.40 **Benefit:** 75% = $126.30 85% = $143.15
	NECK
56101	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (K) (Anaes.) **Fee:** $230.00 **Benefit:** 75% = $172.50 85% = $195.50
56107	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (K) (Anaes.) **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00
56141	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56841 applies (R) (NK) (Anaes.) **Fee:** $116.45 **Benefit:** 75% = $87.35 85% = $99.00
56147	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56847 applies (R) (NK) (Anaes.) **Fee:** $171.60 **Benefit:** 75% = $128.70 85% = $145.90
	SPINE
56219	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $326.20 **Benefit:** 75% = $244.65 85% = $277.30
56220	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56221	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56223	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56224	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70

56225	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken, only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56226	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56227	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
56228	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
56229	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
56230	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium, and with any scans to the cerival region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56231	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56232	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56233	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56220, 56221 and 56223 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56234	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56224, 56225 and 56226 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70

	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56235	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56227, 56228 and 56229 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $122.45 **Benefit:** 75% = $91.85 85% = $104.10
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56236	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56230, 56231 and 56232 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56237	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56238	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56239	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $122.45 **Benefit:** 75% = $91.85 85% = $104.10
56240	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56259	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $164.80 **Benefit:** 75% = $123.60 85% = $140.10
	CHEST AND UPPER ABDOMEN
56301	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.) **Fee:** $295.00 **Benefit:** 75% = $221.25 85% = $250.75
56307	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
56341	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56841 or 57041 applies and not including a study performed to exclude coronary artery calcification (R) (NK) (Anaes.) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05

56347	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies and not including a study performed to exclude coronary artery calcification (R) (NK) (Anaes.) **Fee:** $202.00 **Benefit:** 75% = $151.50 85% = $171.70
	UPPER ABDOMEN
56401	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K) (Anaes.) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56407	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (K) (Anaes.) **Fee:** $360.00 **Benefit:** 75% = $270.00 85% = $306.00
56409	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (K) (Anaes.) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56412	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K) (Anaes.) **Fee:** $360.00 **Benefit:** 75% = $270.00 85% = $306.00
56441	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest), without intravenous contrast medium, not being a service to which item 56341, 56541, 56841 or 57041 applies (R) (NK) (Anaes.) **Fee:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
56447	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56347, 56547, 56847 or 57047 applies (R) (NK) (Anaes.) **Fee:** $181.50 **Benefit:** 75% = $136.15 85% = $154.30
56449	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium, not being a service to which item 56441 applies (R) (NK) (Anaes.) **Fee:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
56452	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium, and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) (Anaes.) **Fee:** $181.50 **Benefit:** 75% = $136.15 85% = $154.30
	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:** $385.00 **Benefit:** 75% = $288.75 85% = $327.25
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:** $480.05 **Benefit:** 75% = $360.05 85% = $418.55
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:** $193.15 **Benefit:** 75% = $144.90 85% = $164.20
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:** $243.75 **Benefit:** 75% = $182.85 85% = $207.20

56549	COMPUTED TOMOGRAPHY OF COLON, following incomplete colonoscopy in the preceding 3 months, where the patient is referred by the specialist or consultant physician who performed the incomplete colonoscopy, not being a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.) **Fee:** $385.00 **Benefit:** 75% = $288.75 85% = $327.25
56551	COMPUTED TOMOGRAPHY OF COLON, where the patient is referred by a specialist or consultant physician and where (a) one of the following conditions is present: (i) fistulous disease (ii) obstructed colon (iii) megacolon and where (b) the request specifies the condition; not being a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.) **Fee:** $385.00 **Benefit:** 75% = $288.75 85% = $327.25
	EXTREMITIES
56619	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $220.00 **Benefit:** 75% = $165.00 85% = $187.00
56625	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $334.65 **Benefit:** 75% = $251.00 85% = $284.50
56659	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $112.10 **Benefit:** 75% = $84.10 85% = $95.30
56665	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium, and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIL. of explanatory notes to this Category)* **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30
	CHEST, ABDOMEN, PELVIS AND NECK
56801	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.) **Fee:** $466.55 **Benefit:** 75% = $349.95 85% = $405.05
56807	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.) **Fee:** $560.00 **Benefit:** 75% = $420.00 85% = $498.50
56841	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium not including a study performed to exclude coronary artery calcification (R) (NK) (Anaes.) **Fee:** $233.35 **Benefit:** 75% = $175.05 85% = $198.35
56847	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification (R) (NK) (Anaes.) **Fee:** $283.85 **Benefit:** 75% = $212.90 85% = $241.30
	BRAIN, CHEST AND UPPER ABDOMEN
57001	COMPUTED TOMOGRAPHY - scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.) **Fee:** $466.65 **Benefit:** 75% = $350.00 85% = $405.15

57007	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification(R) (K) (Anaes.) **Fee:** $567.75 **Benefit:** 75% = $425.85 85% = $506.25
57041	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification(R) (NK) (Anaes.) **Fee:** $233.40 **Benefit:** 75% = $175.05 85% = $198.40
57047	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification(R) (NK) (Anaes.) **Fee:** $283.90 **Benefit:** 75% = $212.95 85% = $241.35
	PELVIMETRY
57201	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (K) (Anaes.) **Fee:** $155.20 **Benefit:** 75% = $116.40 85% = $131.95
57247	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (NK) (Anaes.) **Fee:** $77.55 **Benefit:** 75% = $58.20 85% = $65.95
	INTERVENTIONAL TECHNIQUES
57341	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) (Anaes.) **Fee:** $470.00 **Benefit:** 75% = $352.50 85% = $408.50
57345	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) (Anaes.) **Fee:** $241.60 **Benefit:** 75% = $181.20 85% = $205.40
	SPIRAL ANGIOGRAPHY
57350	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months (R) (K) (Anaes.) **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $448.50
57351	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; acute ruptured aneurysm; or acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months. (R) (K) (Anaes.) **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $448.50
57355	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months (R) (NK) (Anaes.) **Fee:** $264.15 **Benefit:** 75% = $198.15 85% = $224.55

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY
	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; or acute ruptured aneurysm; acute dissection of the aorta, carotid or vertebral artery; and c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months. (R) (NK) (Anaes.)	
57356	**Fee:** $264.15 **Benefit:** 75% =$198.15 85% =$224.55	

	GROUP I3 - DIAGNOSTIC RADIOLOGY		
	SUBGROUP 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES		
57506	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (NR) **Fee:** $29.75	**Benefit:** 75% = $22.35	85% = $25.30
57509	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (R) **Fee:** $39.75	**Benefit:** 75% = $29.85	85% = $33.80
57512	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (NR) **Fee:** $40.50	**Benefit:** 75% = $30.40	85% = $34.45
57515	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (R) **Fee:** $54.00	**Benefit:** 75% = $40.50	85% = $45.90
57518	FOOT, ANKLE, LEG, KNEE OR FEMUR (NR) **Fee:** $32.50	**Benefit:** 75% = $24.40	85% = $27.65
57521	FOOT, ANKLE, LEG, KNEE OR FEMUR (R) **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
57524	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) **Fee:** $49.40	**Benefit:** 75% = $37.05	85% = $42.00
57527	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (R) **Fee:** $65.75	**Benefit:** 75% = $49.35	85% = $55.90
	SUBGROUP 2 - RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS		
57700	SHOULDER OR SCAPULA (NR) **Fee:** $40.50	**Benefit:** 75% = $30.40	85% = $34.45
57703	SHOULDER OR SCAPULA (R) **Fee:** $54.00	**Benefit:** 75% = $40.50	85% = $45.90
57706	CLAVICLE (NR) **Fee:** $32.50	**Benefit:** 75% = $24.40	85% = $27.65
57709	CLAVICLE (R) **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
57712	HIP JOINT (R) **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57715	PELVIC GIRDLE (R) **Fee:** $60.90	**Benefit:** 75% = $45.70	85% = $51.80
57721	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) **Fee:** $99.25	**Benefit:** 75% = $74.45	85% = $84.40
	SUBGROUP 3 - RADIOGRAPHIC EXAMINATION OF HEAD		
57901	SKULL, not in association with item 57902 (R) **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
57902	CEPHALOMETRY, not in association with item 57901 (R) **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
57903	SINUSES (R) **Fee:** $47.30	**Benefit:** 75% = $35.50	85% = $40.25
57906	MASTOIDS (R) **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
57909	PETROUS TEMPORAL BONES (R) **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85

57912	FACIAL BONES orbit, maxilla or malar, any or all (R) **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57915	MANDIBLE, not by orthopantomography technique (R) **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57918	SALIVARY CALCULUS (R) **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57921	NOSE (R) **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57924	EYE (R) **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57927	TEMPOROMANDIBULAR JOINTS (R) **Fee:** $49.65	**Benefit:** 75% = $37.25	85% = $42.25
57930	TEETH SINGLE AREA (R) **Fee:** $32.90	**Benefit:** 75% = $24.70	85% = $28.00
57933	TEETH FULL MOUTH (R) **Fee:** $78.25	**Benefit:** 75% = $58.70	85% = $66.55
57939	PALATOPHARYNGEAL STUDIES with fluoroscopic screening (R) **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
57942	PALATOPHARYNGEAL STUDIES without fluoroscopic screening (R) **Fee:** $49.65	**Benefit:** 75% = $37.25	85% = $42.25
57945	LARYNX, LATERAL AIRWAYS AND SOFT TISSUES OF THE NECK, not being a service associated with a service to which item 57939 or 57942 applies (R) **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
57960	Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (R) **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
57963	Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (R) **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
57966	Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
57969	Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (R) **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
	SUBGROUP 4 - RADIOGRAPHIC EXAMINATION OF SPINE		
58100	SPINE CERVICAL (R) **Fee:** $67.15	**Benefit:** 75% = $50.40	85% = $57.10
58103	SPINE THORACIC (R) **Fee:** $55.10	**Benefit:** 75% = $41.35	85% = $46.85
58106	SPINE LUMBOSACRAL (R) **Fee:** $77.00	**Benefit:** 75% = $57.75	85% = $65.45
58108	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) **Fee:** $132.90	**Benefit:** 75% = $99.70	85% = $113.00
58109	SPINE SACROCOCCYGEAL (R) **Fee:** $47.00	**Benefit:** 75% = $35.25	85% = $39.95

	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
58112	Spine, two examinations of the kind referred to in items 58100, 58103, 58106 and 58109 (R) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
58115	Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) **Fee:** $132.90 **Benefit:** 75% = $99.70 85% = $113.00
	SUBGROUP 5 - BONE AGE STUDY AND SKELETAL SURVEYS
58300	BONE AGE STUDY (R) **Fee:** $40.10 **Benefit:** 75% = $30.10 85% = $34.10
58306	SKELETAL SURVEY (R) **Fee:** $89.40 **Benefit:** 75% = $67.05 85% = $76.00
	SUBGROUP 6 - RADIOGRAPHIC EXAMINATION OF THORACIC REGION
58500	CHEST (lung fields) by direct radiography (NR) **Fee:** $35.35 **Benefit:** 75% = $26.55 85% = $30.05
58503	CHEST (lung fields) by direct radiography (R) **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
58506	CHEST (lung fields) by direct radiography with fluoroscopic screening (R) **Fee:** $60.75 **Benefit:** 75% = $45.60 85% = $51.65
58509	THORACIC INLET OR TRACHEA (R) **Fee:** $39.75 **Benefit:** 75% = $29.85 85% = $33.80
58521	LEFT RIBS, RIGHT RIBS OR STERNUM (R) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
58524	LEFT AND RIGHT RIBS, LEFT RIBS AND STERNUM, OR RIGHT RIBS AND STERNUM (R) **Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05
58527	LEFT RIBS, RIGHT RIBS AND STERNUM (R) **Fee:** $69.40 **Benefit:** 75% = $52.05 85% = $59.00
	SUBGROUP 7 - RADIOGRAPHIC EXAMINATION OF URINARY TRACT
58700	PLAIN RENAL ONLY (R) **Fee:** $46.05 **Benefit:** 75% = $34.55 85% = $39.15
58706	INTRAVENOUS PYELOGRAPHY, with or without preliminary plain films and with or without tomography - (R) **Fee:** $157.90 **Benefit:** 75% = $118.45 85% = $134.25
58715	ANTEGRADE OR RETROGRADE PYELOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - 1 side - (R) **Fee:** $151.55 **Benefit:** 75% = $113.70 85% = $128.85
58718	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) **Fee:** $126.10 **Benefit:** 75% = $94.60 85% = $107.20
58721	RETROGRADE MICTURATING CYSTOURETHROGRAPHY, with preparation and contrast injection - (R) (Anaes.) **Fee:** $138.25 **Benefit:** 75% = $103.70 85% = $117.55
	SUBGROUP 8 - RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM
58900	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (NR) *(See para DIM. of explanatory notes to this Category)* **Fee:** $35.70 **Benefit:** 75% = $26.80 85% = $30.35

58903	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (R) *(See para DIM. of explanatory notes to this Category)* **Fee:** $47.60 **Benefit:** 75% = $35.70 85% = $40.50
58909	BARIUM or other opaque meal of 1 or more of PHARYNX, OESOPHAGUS, STOMACH OR DUODENUM, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939 or 57942 or 57945 applies - (R) **Fee:** $89.95 **Benefit:** 75% = $67.50 85% = $76.50
58912	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH, DUODENUM AND FOLLOW THROUGH TO COLON, with or without screening of chest, with or without preliminary plain film (R) **Fee:** $110.25 **Benefit:** 75% = $82.70 85% = $93.75
58915	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) **Fee:** $78.95 **Benefit:** 75% = $59.25 85% = $67.15
58916	SMALL BOWEL ENEMA, barium or other opaque study of the small bowel, including DUODENAL INTUBATION, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - (R) (Anaes.) **Fee:** $138.50 **Benefit:** 75% = $103.90 85% = $117.75
58921	OPAQUE ENEMA, with or without air contrast study and with or without preliminary plain films - (R) **Fee:** $135.25 **Benefit:** 75% = $101.45 85% = $115.00
58924	GRAHAM'S TEST (cholecystography), with preliminary plain films and with or without tomography - (R) **Fee:** $84.05 **Benefit:** 75% = $63.05 85% = $71.45
58927	CHOLEGRAPHY DIRECT, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - (R) **Fee:** $76.45 **Benefit:** 75% = $57.35 85% = $65.00
58933	CHOLEGRAPHY, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R) **Fee:** $205.60 **Benefit:** 75% = $154.20 85% = $174.80
58936	CHOLEGRAPHY, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R) **Fee:** $195.95 **Benefit:** 75% = $147.00 85% = $166.60
58939	DEFAECOGRAM (R) **Fee:** $139.30 **Benefit:** 75% = $104.50 85% = $118.45
	SUBGROUP 9 - RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES
59103	FOREIGN BODY, LOCALISATION OF AND REPORT, not being a service to which another item in this Group applies (R) **Derived Fee:** The fee for radiographic examination of the area and report plus an amount of $21.30
	SUBGROUP 10 - RADIOGRAPHIC EXAMINATION OF BREASTS
59300	*(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)* MAMMOGRAPHY OF BOTH BREASTS, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (R) *(See para DIM. of explanatory notes to this Category)* **Fee:** $89.50 **Benefit:** 75% = $67.15 85% = $76.10
59303	MAMMOGRAPHY OF ONE BREAST, if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) *(See para DIM. of explanatory notes to this Category)* **Fee:** $53.95 **Benefit:** 75% = $40.50 85% = $45.90

59306	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) **Fee:** $100.30	**Benefit:** 75% = $75.25	85% = $85.30
59309	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) **Fee:** $200.60	**Benefit:** 75% = $150.45	85% = $170.55
59312	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, in conjunction with a surgical procedure on each breast, using interventional techniques - (R) **Fee:** $87.00	**Benefit:** 75% = $65.25	85% = $73.95
59314	RADIOGRAPHIC EXAMINATION OF 1 BREAST, in conjunction with a surgical procedure using interventional techniques - (R) **Fee:** $52.50	**Benefit:** 75% = $39.40	85% = $44.65
59318	RADIOGRAPHIC EXAMINATION OF EXCISED BREAST TISSUE to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 31536 - (R) **Fee:** $47.05	**Benefit:** 75% = $35.30	85% = $40.00
	SUBGROUP 11 - RADIOGRAPHIC EXAMINATION IN CONNECTION WITH PREGNANCY		
59503	PELVIMETRY, not being a service associated with a service to which item 57201 applies (R) **Fee:** $89.40	**Benefit:** 75% = $67.05	85% = $76.00
	SUBGROUP 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA		
59700	DISCOGRAPHY, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) **Fee:** $96.55	**Benefit:** 75% = $72.45	85% = $82.10
59703	DACRYOCYSTOGRAPHY, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R) **Fee:** $75.90	**Benefit:** 75% = $56.95	85% = $64.55
59712	HYSTEROSALPINGOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) **Fee:** $113.70	**Benefit:** 75% = $85.30	85% = $96.65
59715	BRONCHOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) **Fee:** $143.55	**Benefit:** 75% = $107.70	85% = $122.05
59718	PHLEBOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) **Fee:** $134.65	**Benefit:** 75% = $101.00	85% = $114.50
59724	MYELOGRAPHY, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies - (R) (Anaes.) *(See para DIM. of explanatory notes to this Category)* **Fee:** $226.45	**Benefit:** 75% = $169.85	85% = $192.50
59733	SIALOGRAPHY, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies - (R) **Fee:** $107.70	**Benefit:** 75% = $80.80	85% = $91.55
59736	VASOEPIDIDYMOGRAPHY, 1 side, for other than an investigation for reversal of previous sterilisation - (R) **Fee:** $62.00	**Benefit:** 75% = $46.50	85% = $52.70
59739	SINOGRAM OR FISTULOGRAM, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R) **Fee:** $73.75	**Benefit:** 75% = $55.35	85% = $62.70
59751	ARTHROGRAPHY, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (R) **Fee:** $139.15	**Benefit:** 75% = $104.40	85% = $118.30
59754	LYMPHANGIOGRAPHY, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R) **Fee:** $219.35	**Benefit:** 75% = $164.55	85% = $186.45
59760	PERITONEOGRAM (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (R) **Fee:** $115.15	**Benefit:** 75% = $86.40	85% = $97.90

59763	AIR INSUFFLATION during video - fluoroscopic imaging including associated consultation (R) **Fee:** $133.90 **Benefit:** 75% = $100.45 85% = $113.85
	SUBGROUP 13 - ANGIOGRAPHY
59903	ANGIOCARDIOGRAPHY including the service described in item 59970, 59974 or 61109, not being a service to which item 59912 or 59925 applies (R) (K) (Anaes.) **Fee:** $114.55 **Benefit:** 75% = $85.95 85% = $97.40
59912	SELECTIVE CORONARY ARTERIOGRAPHY (R) (K), including the services described in item 59970, 59974 or 61109, not being a service to which item 59903 or 59925 applies (Anaes.) **Fee:** $305.20 **Benefit:** 75% = $228.90 85% = $259.45
59925	SELECTIVE CORONARY ARTERIOGRAPHY AND ANGIOCARDIOGRAPHY, including the services described in items 59903, 59912, 59970, 59974 or 61109 (R) (K) (Anaes.) **Fee:** $362.45 **Benefit:** 75% = $271.85 85% = $308.10
59970	ANGIOGRAPHY AND/OR DIGITAL SUBTRACTION ANGIOGRAPHY with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (R) (K) (Anaes.) *(See para DIM. of explanatory notes to this Category)* **Fee:** $168.30 **Benefit:** 75% = $126.25 85% = $143.10
59971	ANGIOCARDIOGRAPHY including the service described in item 59970, 59974 or 61109, not being a service to which item 59972 or 59973 applies (R) (NK) (Anaes.) **Fee:** $57.30 **Benefit:** 75% = $43.00 85% = $48.75
59972	SELECTIVE CORONARY ARTERIOGRAPHY (R) (NK), including the service described in item 59970, 59974 or 61109, not being a service to which item 59971 or 59973 applies (Anaes.) **Fee:** $152.60 **Benefit:** 75% = $114.45 85% = $129.75
59973	SELECTIVE CORONARY ARTERIOGRAPHY AND ANGIOCARDIOGRAPHY, including the services described in items 59970, 59971, 59972, 59974 or 61109 (R) (NK) (Anaes.) **Fee:** $181.25 **Benefit:** 75% = $135.95 85% = $154.10
59974	ANGIOGRAPHY AND/OR DIGITAL SUBTRACTION ANGIOGRAPHY with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (R) (NK) (Anaes.) *(See para DIM. of explanatory notes to this Category)* **Fee:** $84.20 **Benefit:** 75% = $63.15 85% = $71.60
	BY DIGITAL SUBTRACTION TECHNIQUE
60000	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (Anaes.) **Fee:** $564.00 **Benefit:** 75% = $423.00 85% = $502.50
60003	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (Anaes.) **Fee:** $827.10 **Benefit:** 75% = $620.35 85% = $765.60
60006	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (Anaes.) **Fee:** $1,176.10 **Benefit:** 75% = $882.10 85% = $1,114.60
60009	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (Anaes.) **Fee:** $1,376.30 **Benefit:** 75% = $1,032.25 85% = $1,314.80
60012	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 1 to 3 data acquisition runs (R) (Anaes.) **Fee:** $564.00 **Benefit:** 75% = $423.00 85% = $502.50
60015	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 4 to 6 data acquisition runs (R) (Anaes.) **Fee:** $827.10 **Benefit:** 75% = $620.35 85% = $765.60
60018	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 7 to 9 data acquisition runs (R) (Anaes.) **Fee:** $1,176.10 **Benefit:** 75% = $882.10 85% = $1,114.60

DIAGNOSTIC RADIOLOGY				ANGIOGRAPHY
60021	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 10 or more data acquisition runs (R) (Anaes.) **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,314.80	
60024	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 1 to 3 data acquisition runs (R) (Anaes.) **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $502.50	
60027	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 4 to 6 data acquisition runs (R) (Anaes.) **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $765.60	
60030	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 7 to 9 data acquisition runs (R) (Anaes.) **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,114.60	
60033	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 10 or more data acquisition runs (R) (Anaes.) **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,314.80	
60036	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.) **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $502.50	
60039	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.) **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $765.60	
60042	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.) **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,114.60	
60045	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 10 or more data acquisition runs (R) (Anaes.) **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,314.80	
60048	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.) **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $502.50	
60051	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.) **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $765.60	
60054	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.) **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,114.60	
60057	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.) **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,314.80	
60060	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.) **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $502.50	
60063	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.) **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $765.60	
60066	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.) **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,114.60	
60069	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.) **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,314.80	
60072	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 1 vessel (NR) (Anaes.) **Fee:** $48.10	**Benefit:** 75% = $36.10	85% = $40.90	
60075	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 2 vessels (NR) (Anaes.) **Fee:** $96.10	**Benefit:** 75% = $72.10	85% = $81.70	

60078	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 3 or more vessels (NR) (Anaes.) **Fee:** $144.25 **Benefit:** 75% =$108.20 85% =$122.65
	SUBGROUP 14 - TOMOGRAPHY
60100	TOMOGRAPHY OF ANY REGION (R) (Anaes.) **Fee:** $60.75 **Benefit:** 75% =$45.60 85% =$51.65
	SUBGROUP 15 - FLUOROSCOPIC EXAMINATION
60500	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.) **Fee:** $43.40 **Benefit:** 75% =$32.55 85% =$36.90
60503	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R) **Fee:** $29.75 **Benefit:** 75% =$22.35 85% =$25.30
60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Table applies (R) **Fee:** $63.75 **Benefit:** 75% =$47.85 85% =$54.20
60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Table applies (R) **Fee:** $98.90 **Benefit:** 75% =$74.20 85% =$84.10
	SUBGROUP 16 - PREPARATION FOR RADIOLOGICAL PROCEDURE
60918	ARTERIOGRAPHY (peripheral) or PHLEBOGRAPHY 1 vessel, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes.) **Fee:** $47.15 **Benefit:** 75% =$35.40 85% =$40.10
60927	SELECTIVE ARTERIOGRAM or PHLEBOGRAM, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes.) **Fee:** $38.05 **Benefit:** 75% =$28.55 85% =$32.35
	SUBGROUP 17 - INTERVENTIONAL TECHNIQUES
61109	FLUOROSCOPY in an ANGIOGRAPHY SUITE with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this Table applies (R) **Fee:** $258.90 **Benefit:** 75% =$194.20 85% =$220.10

	GROUP I4 - NUCLEAR MEDICINE IMAGING		
61302	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) **Fee:** $444.40	**Benefit:** 75% = $333.30	85% = $382.90
61303	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $559.70	**Benefit:** 75% = $419.80	85% = $498.20
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:** $702.65	**Benefit:** 75% = $527.00	85% = $641.15
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:** $826.65	**Benefit:** 75% = $620.00	85% = $765.15
61310	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) **Fee:** $363.65	**Benefit:** 75% = $272.75	85% = $309.15
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:** $300.35	**Benefit:** 75% = $225.30	85% = $255.30
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:** $415.85	**Benefit:** 75% = $311.90	85% = $354.35
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:** $377.40	**Benefit:** 75% = $283.05	85% = $320.80
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:** $487.50	**Benefit:** 75% = $365.65	85% = $426.00
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:** $226.65	**Benefit:** 75% = $170.00	85% = $192.70
61328	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) **Fee:** $225.40	**Benefit:** 75% = $169.05	85% = $191.60
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:** $250.50	**Benefit:** 75% = $187.90	85% = $212.95
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:** $438.95	**Benefit:** 75% = $329.25	85% = $377.45
61352	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) **Fee:** $256.80	**Benefit:** 75% = $192.60	85% = $218.30
61353	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $382.75	**Benefit:** 75% = $287.10	85% = $325.35
61356	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) **Fee:** $388.90	**Benefit:** 75% = $291.70	85% = $330.60
61360	HEPATOBILIARY STUDY, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R) **Fee:** $399.35	**Benefit:** 75% = $299.55	85% = $339.45

61361	HEPATOBILIARY STUDY with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R) **Fee:** $456.85	**Benefit:** 75% = $342.65	85% = $395.35
61364	BOWEL HAEMORRHAGE STUDY (R) **Fee:** $492.05	**Benefit:** 75% = $369.05	85% = $430.55
61368	MECKEL'S DIVERTICULUM STUDY (R) **Fee:** $220.90	**Benefit:** 75% = $165.70	85% = $187.80
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:** $1,995.80	**Benefit:** 75% = $1,496.85	85% = $1,934.30
61372	SALIVARY STUDY (R) **Fee:** $220.90	**Benefit:** 75% = $165.70	85% = $187.80
61373	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) **Fee:** $484.85	**Benefit:** 75% = $363.65	85% = $423.35
61376	OESOPHAGEAL CLEARANCE STUDY (R) **Fee:** $141.95	**Benefit:** 75% = $106.50	85% = $120.70
61381	GASTRIC EMPTYING STUDY, using single tracer (R) **Fee:** $568.65	**Benefit:** 75% = $426.50	85% = $507.15
61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) **Fee:** $618.75	**Benefit:** 75% = $464.10	85% = $557.25
61384	RADIONUCLIDE COLONIC TRANSIT STUDY (R) **Fee:** $680.90	**Benefit:** 75% = $510.70	85% = $619.40
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) **Fee:** $329.20	**Benefit:** 75% = $246.90	85% = $279.85
61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) **Fee:** $426.50	**Benefit:** 75% = $319.90	85% = $365.00
61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) **Fee:** $366.90	**Benefit:** 75% = $275.20	85% = $311.90
61390	RENAL STUDY with diuretic administration following a baseline study (R) **Fee:** $405.90	**Benefit:** 75% = $304.45	85% = $345.05
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:** $599.50	**Benefit:** 75% = $449.65	85% = $538.00
61397	CYSTOURETEROGRAM (R) **Fee:** $244.40	**Benefit:** 75% = $183.30	85% = $207.75
61401	TESTICULAR STUDY (R) **Fee:** $160.70	**Benefit:** 75% = $120.55	85% = $136.60
61402	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $599.05	**Benefit:** 75% = $449.30	85% = $537.55
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:** $342.55	**Benefit:** 75% = $256.95	85% = $291.20
61409	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) **Fee:** $864.85	**Benefit:** 75% = $648.65	85% = $803.35

61413	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) **Fee:** $223.70	**Benefit:** 75% =$167.80	85% =$190.15
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:** $117.65	**Benefit:** 75% =$88.25	85% =$100.05
61421	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) **Fee:** $475.05	**Benefit:** 75% =$356.30	85% =$413.55
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:** $594.75	**Benefit:** 75% =$446.10	85% =$533.25
61426	WHOLE BODY STUDY using iodine (R) **Fee:** $549.30	**Benefit:** 75% =$412.00	85% =$487.80
61429	WHOLE BODY STUDY using gallium (R) **Fee:** $537.60	**Benefit:** 75% =$403.20	85% =$476.10
61430	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) **Fee:** $652.90	**Benefit:** 75% =$489.70	85% =$591.40
61433	WHOLE BODY STUDY using cells labelled with technetium (R) **Fee:** $492.05	**Benefit:** 75% =$369.05	85% =$430.55
61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) **Fee:** $609.30	**Benefit:** 75% =$457.00	85% =$547.80
61437	WHOLE BODY STUDY using thallium (R) **Fee:** $537.40	**Benefit:** 75% =$403.05	85% =$475.90
61438	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) **Fee:** $666.30	**Benefit:** 75% =$499.75	85% =$604.80
61441	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) **Fee:** $484.85	**Benefit:** 75% =$363.65	85% =$423.35
61442	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (R) **Fee:** $744.90	**Benefit:** 75% =$558.70	85% =$683.40
61445	BONE MARROW STUDY - localised using technetium labelled agent (R) **Fee:** $283.95	**Benefit:** 75% =$213.00	85% =$241.40
61446	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) **Fee:** $330.25	**Benefit:** 75% =$247.70	85% =$280.75
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:** $451.70	**Benefit:** 75% =$338.80	85% =$390.20
61450	LOCALISED STUDY using gallium (R) **Fee:** $393.60	**Benefit:** 75% =$295.20	85% =$334.60
61453	LOCALISED STUDY using gallium, with single photon emission tomography (R) **Fee:** $509.60	**Benefit:** 75% =$382.20	85% =$448.10
61454	LOCALISED STUDY using cells labelled with technetium (R) **Fee:** $344.65	**Benefit:** 75% =$258.50	85% =$293.00
61457	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) **Fee:** $465.80	**Benefit:** 75% =$349.35	85% =$404.30
61458	LOCALISED STUDY using thallium (R) **Fee:** $393.00	**Benefit:** 75% =$294.75	85% =$334.05

NUCLEAR MEDICINE IMAGING				NUCLEAR MEDICINE IMAGING
61461	LOCALISED STUDY using thallium, with single photon emission tomography (R) **Fee:** $522.60	**Benefit:** 75% ~~=~~$391.95	85% ~~=~~$461.10	
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 $129.00			
61465	VENOGRAPHY (R) **Fee:** $262.85	**Benefit:** 75% ~~=~~$197.15	85% ~~=~~$223.45	
61469	LYMPHOSCINTIGRAPHY (R) **Fee:** $344.65	**Benefit:** 75% ~~=~~$258.50	85% ~~=~~$293.00	
61473	THYROID STUDY including uptake measurement when undertaken (R) **Fee:** $173.65	**Benefit:** 75% ~~=~~$130.25	85% ~~=~~$147.65	
61480	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) **Fee:** $383.00	**Benefit:** 75% ~~=~~$287.25	85% ~~=~~$325.55	
61484	ADRENAL STUDY, with imaging on 2 or more separate occasions (R) **Fee:** $872.15	**Benefit:** 75% ~~=~~$654.15	85% ~~=~~$810.65	
61485	ADRENAL STUDY, with imaging on 2 or more occasions and renal localisation and single photon emission tomography when undertaken (R) **Fee:** $989.30	**Benefit:** 75% ~~=~~$742.00	85% ~~=~~$927.80	
61495	TEAR DUCT STUDY (R) **Fee:** $220.90	**Benefit:** 75% ~~=~~$165.70	85% ~~=~~$187.80	
61499	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) **Fee:** $250.50	**Benefit:** 75% ~~=~~$187.90	85% ~~=~~$212.95	
61650	LEUKOSCAN STUDY, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to <u>*ex-vivo WBC scanning.*</u> (Ministerial Determination) *Note* LeukoScan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. The descriptor does not cover patients who are being investigated for other sites of infection **Fee:** $870.00	**Benefit:** 75% ~~=~~$652.50	85% ~~=~~$808.50	

	GROUP I5 - MAGNETIC RESONANCE IMAGING
	SUBGROUP 1 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS
	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for:
63001	- tumour of the brain or meninges (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63004	- inflammation of the brain or meninges (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63007	- skull base or orbital tumour (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63010	- stereotactic scan of brain, with Fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (R) (Contrast) (Anaes.) **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
	SUBGROUP 2 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 2 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for:
63040	- acoustic neuroma (R) (Contrast) (Anaes.) **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
63043	- pituitary tumour (R) (Contrast) (Anaes.) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63046	- toxic or metabolic or ischaemic encephalopathy (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63049	- demyelinating disease of the brain (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63052	- congenital malformation of the brain or meninges (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63055	- venous sinus thrombosis (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63058	- head trauma (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63061	- epilepsy (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63064	- stroke (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63067	- carotid or vertebral artery desection (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63070	- intracranial aneurysm (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63073	- intracranial arteriovenous malformation (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

	SUBGROUP 3 - SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 3 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING AND MAGNETIC RESONANCE ANGIOGRAPHY of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and neck vessls** for:
63101	- stroke (R) (Contrast) (Anaes.) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
	SUBGROUP 4 - SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS
	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for:
63111	- tumour of the central nervous system or meninges (R) (Contrast) (Anaes.) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
63114	- inflammation of the central nervous system or meninges (R) (Contrast) (Anaes.) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
	SUBGROUP 5 - SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 5 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for:
63125	- demyelinating disease of the central nervous system (R) (Contrast) (Anaes.) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
63128	- congenital malformation of the central nervous system or meninges (R) (Contrast) (Anaes.) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
63131	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
	SUBGROUP 6 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for:
63151	- infection (R) (Contrast) (Anaes.) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63154	- tumour (R) (Contrast) (Anaes.) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
	SUBGROUP 7 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 7 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for:
63161	- demyelinating (R) (Contrast) (Anaes.) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63164	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65

	myelopathy (R) (Contrast) (Anaes.)		
63167	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.)		
63170	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- cervical radiculopathy (R) (Contrast) (Anaes.)		
63173	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- sciatica (R) (Contrast) (Anaes.)		
63176	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- spinal canal stenosis (R) (Contrast) (Anaes.)		
63179	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- previous spinal surgery (R) (Contrast) (Anaes.)		
63182	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- trauma (R) (Anaes.)		
63185	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	SUBGROUP 8 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS		
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for:		
	- infection (R) (Contrast) (Anaes.)		
63201	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50
	- tumour (R) (Contrast) (Anaes.)		
63204	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50
	SUBGROUP 9 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 9 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for:		
	- demyelinating disease (R) (Contrast) (Anaes.)		
63219	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50
	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.)		
63222	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50
	- myelopathy (R) (Contrast) (Anaes.)		
63225	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50
	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.)		
63228	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50
	- cervical radiculopathy (R) (Contrast) (Anaes.)		
63231	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50
	- sciatica (R) (Contrast) (Anaes.)		
63234	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50
	- spinal canal stenosis (R) (Contrast) (Anaes.)		
63237	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50
	- previous spinal surgery (R) (Contrast) (Anaes.)		
63240	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $386.50

	- trauma (R) (Anaes.) 63243 **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $386.50
	SUBGROUP 10 - SCAN OF CERVICAL SPINE AND BRACHIAL PLEXUS - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 10 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of cervcial spine and brachial plexus** for:
	- tumour (R) (Contrast) (Anaes.) 63271 **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
	- trauma (R) (Contrast) (Anaes.) 63274 **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
	- cervical radiculopathy (R) (Contrast) (Anaes.) 63277 **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
	- previous surgery (R) (Contrast) (Anaes.) 63280 **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $431.30
	SUBGROUP 11 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for:
	- tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (R) (Contrast) (Anaes.) 63301 **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (R) (Contrast) (Anaes.) 63304 **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
	- osteonecrosis (R) (Contrast) (Anaes.) 63307 **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
	SUBGROUP 12 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 12 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for:
	- derangement of hip or its supporting structures (R) (Contrast) (Anaes.) 63322 **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	- derangment of shoulder or its supporting structures (R) (Contrast) (Anaes.) 63325 **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	- derangment of knee or its supporting structures (R) (Contrast) (Anaes.) 63328 **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	- derangment of ankle and/or foot or its supporting structures (R) (Contrast) (Anaes.) 63331 **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	- derangment of one or both temporomandibular joints or their supporting structures (R) (Contrast) (Anaes.) 63334 **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
	- derangment of wrist and/or hand or its supporting structures (R) (Contrast) (Anaes.) 63337 **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $386.50
	- derangment of elbow or its supporting structures (R) (Contrast) (Anaes.) 63340 **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

	SUBGROUP 13 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
63361	**NOTE: Benefits are payable for each service included by Subgroup 13 on two occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - Gaucher disease (R) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	SUBGROUP 14 - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
63385	**NOTE: Benefits are payable for each service included by Subgroup 14 on two occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of cardiovascular system** for: - congenital disease of the heart or a great vessel (R) (Contrast) (Anaes.) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $386.50
63388	- tumour of the heart or a great vessel (R) (Contrast) (Anaes.) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $386.50
63391	- abnormality of thoracic aorta (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	SUBGROUP 15 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
63401	**NOTE: Benefits are payable for each service included by Subgroup 15 on three occasions only in any 12 month period** MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for: - vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63404	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	SUBGROUP 16 - MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
63416	**NOTE: Benefits are payable for each service included by Subgroup 16 on one occasion only in any 12 month period** MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	SUBGROUP 17 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
63425	**NOTE: Benefits are payable for each service included by Subgroup 17 on two occasions only in any 12 month period, for previously diagnosed conditions** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - post-inflammatory or post-traumatic physeal fusion (R) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63428	- Gaucher disease (R) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

	SUBGROUP 18 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
63440	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - pelvic or abdominal mass (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63443	- mediastinal mass (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63446	- congenital uterine or anorectal abnormality (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	SUBGROUP 19 - SCAN OF BODY - FOR SPECIFIED CONDITIONS
63461	**NOTE: Benefits are payable for each service included by Subgroup 19 on one occasion only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of body** for: - adrenal mass in a patient with malignancy which is otherwise resecetable (R) (Anaes.) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
	SUBGROUP 20 - SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS
63470	**NOTE: Benefits are payable for a service included by Subgroup 20 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 of: - Pelvis for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63473	- Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Contrast) (Anaes.) **Fee:** $627.20 **Benefit:** 75% = $470.40 85% = $565.70
	SUBGROUP 21 - MODIFYING ITEMS
63491	**NOTE: Benefits in Subgroup 21 are only payable for modifying items where claimed simultaneously with MRI services. Modifiers for sedation and anaesthesia may not be claimed for the same service.** Modifying items for use with MAGNETIC RESONANCE IMAGING or MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician. **Scan performed**: - involves the use of contrast agent for eligible Magnetic Resonance Imaging items (Note: (Contrast) denotes an item eligible for use with this item) **Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
63494	- involves use of intravenous or intramuscular sedation on a patient **Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
63497	- on a patient under anaesthetic in the presence of a medical practitioner qualified to perform an anaesthetic **Fee:** $156.80 **Benefit:** 75% = $117.60 85% = $133.30

GROUP I6 - MANAGEMENT OF BULK-BILLED SERVICES

64990	A diagnostic imaging service to which an item in this table (other than this item or item 64991) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital or day-hospital facility; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service *(See para DIP. of explanatory notes to this Category)* **Fee:** $6.05 **Benefit:** 85% = $5.15
64991	A diagnostic imaging service to which an item in this table (other than this item or item 64990) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital or day-hospital facility; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service; and (e) the service is provided at, or from, a practice location in: (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) A geographical area included in any of the following SSD spatial units: (A) Beaudesert Shire Part A (B) Belconnen (C) Darwin City (D) Eastern Outer Melbourne (E) East Metropolitan (F) Frankston City (G) Gosford-Wyong (H) Greater Geelong City Part A (I) Gungahlin-Hall (J) Ipswich City (part in BSD) (K) Litchfield Shire (L) Melton-Wyndham (M) Mornington Peninsula Shire (N) Newcastle (O) North Canberra (P) Palmerston-East Arm (Q) Pine Rivers Shire (R) Queanbeyan (S) South Canberra (T) South Eastern Outer Melbourne (U) Southern Adelaide (V) South West Metropolitan (W) Thuringowa City Part A (X) Townsville City Part A (Y) Tuggeranong (Z) Weston Creek-Stromlo (ZA) Woden Valley (ZB) Yarra Ranges Shire Part A; or (iv) the geographical area included in the SLA spatial unit of Palm Island (AC) *(See para DIP. of explanatory notes to this Category)* **Fee:** $9.20 **Benefit:** 85% = $7.85

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PATHOLOGY SERVICES

CATEGORY 6

PLEASE NOTE:

The information contained in this Category relates specifically to the Pathology Services Arrangements under Medicare. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the INTRODUCTION and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category.

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CATEGORY 6 - PATHOLOGY SERVICES

PART ONE - OUTLINE OF ARRANGEMENTS

PA. PATHOLOGY SERVICES IN RELATION TO MEDICARE BENEFITS

PA.1 Basic Requirements

PA.1.1 ***Determination of Necessity of Service***

The treating practitioner must determine that the pathology service is necessary.

PA.1.2 ***Request for Service***

The service may only be provided:

(i) in response to a request from the treating practitioner or from another Approved Pathology Practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days); or

(ii) if determined to be necessary by an Approved Pathology Practitioner who is treating the patient.

PA.1.3 ***Provision of Service***

The following conditions relate to provision of services:

(i) the service has to be provided by or on behalf of an Approved Pathology Practitioner;

(ii) the service has to be provided in a pathology laboratory accredited for that kind of service;

(iii) the proprietor of the laboratory where the service is performed must be an Approved Pathology Authority;

(iv) the Approved Pathology Practitioner providing the service must either be the proprietor of the laboratory or party to an agreement, either by way of contract of employment or otherwise, with the proprietor of the laboratory in which the service is provided; and

(v) no benefit will be payable for services provided by an Approved Pathology Practitioner on behalf of an Approved Pathology Authority if they are not performed in the laboratories of that particular Approved Pathology Authority.

PA.1.4 ***Therapeutic Goods Act 1989***

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

PA.2 Exceptions to Basic Requirements

PA.2.1 ***Prescribed Pathology Services***

A prescribed pathology service is a service included in Group P9 of the Pathology Services Table. Group P9 contains 11 services which may be performed by a medical practitioner in his or her own surgery on his or her own patients.

Additionally, benefit is payable only where the service is determined to be necessary by the medical practitioner rendering the service, or is in response to a request by a member of a group of practitioners to which that practitioner belongs (see PO.2 for the definition of a "group of practitioners").

PA.2.2 ***Services Where Request Not Required***

A written request is not required for -

(i) a prescribed pathology service rendered by or on behalf of a medical practitioner upon his or her own patients;

(ii) a pathologist-determinable service. A pathologist-determinable service is a pathology service :

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

(b) that is specified in only one of immunohistochemistry items 72846, 72847 or 72848 or immunocytochemistry items 73059, 73060 or 73061 or electronmicroscopy items 72851 or 72852 and is considered necessary by the Approved Pathology Provider as a consequence of information resulting from a pathology service contained in tissue examination items 72813 – 72836, cytology items 73045 – 73051 or tissue examination items 72813 - 72836 respectively.
Please note: a written request is required for a service contained in items 72813 to 72836 and items 73045 to 73051.

(c) That is specified in one of the antigen detection items 69364 or 69365 and is considered necessary by the specialist pathologist as a consequence of information provided by the requesting practitioner or by the nature or appearance of the specimen or as a consequence of information resulting from a pathology service contained in items 69303, 69306, 69312, 69318, 69321, 69345. Please note: a written request is required for a service contained in items 69303, 69306, 69312, 69318, 69321, 69345 or for a service contained in items 69364 or 69365.

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

PA.3 Circumstances Where Medicare Benefits Not Attracted

PA.3.1 *Services Rendered by Disqualified Practitioner*

Medicare benefits are not payable for pathology services if at the time the service is rendered, the person, by or on whose behalf the service is rendered, is a person in relation to whom a determination is in force in relation to that class of services. That is, where an Approved Pathology Practitioner has breached an undertaking, and a determination has been made that Medicare benefits should not be paid during a specified period (of up to five years) in respect of specified pathology services rendered by the practitioner.

Note: An Approved Pathology Practitioner may be disqualified for reasons other than a breach of undertaking.

PA.3.2 *Certain Pathology Tests Do Not Attract Medicare Benefits*

Certain tests of public health significance do not qualify for payment of Medicare benefits. Examples of services in this category are:

- examination by animal inoculation;
- Guthrie test for phenylketonuria;
- neonatal screening for hypothyroidism (T4/TSH estimation);
- neonatal screening for Cystic Fibrosis;
- neonatal screening for Galactosemia;
- pathology services used with the intention of monitoring the performance enhancing effects of any substance;
- pathology tests carried out on specimens collected from persons occupationally exposed to sexual transmission of
- disease where the purpose of the collection of specimens is for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed.

In addition to the above, certain other tests do not qualify for payment of Medicare benefits. These include:

- cytotoxic food testing;
- pathology services performed for the purposes of tissue audit;
- pathology services performed for the purposes of control estimation, repeat tests (eg. for confirmation of earlier tests on the same specimen, etc);
- preparation of autogenous vaccines;
- tissue banking and preparation procedures;
- pathology services which are performed routinely in association with the termination of pregnancy without there being any indication for the necessity of the services. However, benefits will be paid for the following pathology tests: item 65060 - haemoglobin estimation;
  item 65090 - blood grouping ABO and Rh (D antigen);
  item 65096 - examination of serum for Rh and other blood group antibodies;
- pathology services performed on stillborn babies or cadavers.

PB. REQUESTS

PB.1 Responsibilities of Treating/Requesting Practitioners

PB.1.1 *Form of Request*

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made.

Pathology request forms and combined pathology request/offer to assign forms which are prepared by the pathologists and distributed to requesting practitioners must be approved by Medicare Australia (see PB.2). Written pathology requests from treating practitioners that are not on a form prepared and distributed by a pathologist do not need to be approved. However, all written requests for pathology services should contain the following particulars:

(i) the individual pathology services, or recognised groups of pathology tests to be rendered (see section PQ of these notes for the list of acceptable terms and abbreviations). The description must be sufficient to enable the item in which the service is specified to be identified;

(ii) the requesting practitioner's signature and date of request;

(iii) the surname, initials of given names, practice address and provider number of the requesting practitioner;

(iv) the patient's name and address;

(v) details of the hospital status of the patient, as follows (for benefit rate assessment). That is, whether the patient was or will be, at the time of the service and when the specimen is obtained:

  (a) a private patient in a private hospital, or approved day hospital facility;

  (b) a private patient in a recognised hospital;

  (c) a Medicare (public) patient in a recognised hospital;

  (d) an outpatient of a recognised hospital;

(vi) details of the person to whom the request is directed. A pathology request can be directed to an Approved Pathology Practitioner or an Approved Pathology Authority. If the request is directed to an Approved Pathology Authority, the form must show the full name and address of the Approved Pathology Authority. If the request is directed to an Approved Pathology Practitioner, the form must show the surname, initials or given names and place of practice of the Approved Pathology Practitioner to whom the request is addressed.

PB.1.2 *Offence Not to Confirm an Oral Request*

A requesting practitioner who, without reasonable excuse, does not confirm in writing an oral request within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000, and the request is deemed never to have been made.

PB.2 Responsibilities of Approved Pathology Practitioners

PB.2.1 *Form of Request*

There is no official "request in writing" form, and the requesting practitioner's own stationery, or pre-printed forms supplied by Approved Pathology Practitioners/Authorities are acceptable, provided there are no check lists or "tick-a-box" lists of individual tests or groups of pathology services on the forms. However, pre-printed request forms issued by Approved Pathology Practitioners/Authorities for use by requesting practitioners must be approved by Medicare Australia. Forms submitted for approval should be accompanied by other information or documentation such as that contained in notes for guidance, cover sheets, etc., provided to requesting practitioners.

PB.2.2 *Offence to Provide Unapproved Request Forms*

An Approved Pathology Practitioner or Approved Pathology Authority who, without reasonable excuse, provides (directly or indirectly) to practitioners request forms which are not approved by Medicare Australia, is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000.

PB.2.3 ***Request to Approved Pathology Authority***

It is acceptable for a request to be made to an Approved Pathology Authority who is the proprietor or one of the proprietors of a laboratory instead of making the request to the Approved Pathology Practitioner who renders the service or on whose behalf the service is rendered.

PB.2.4 ***Holding, Retention, Recording and Production of Request Forms***

Approved Pathology Practitioners must hold a request in writing for all services requested by any other practitioner before billing patients. An Approved Pathology Practitioner is required to retain written requests/confirmation of requests for pathology services for 18 months from the day when the service was rendered. This also applies to requests which an Approved Pathology Practitioner receives of which only some tests are referred to another Approved Pathology Practitioner (the first Approved Pathology Practitioner would retain the request for 18 months). If all tests were referred, the second pathologist would retain the original request.

If the written request or written confirmation has been recorded on film or other magnetic medium approved by the Minister for Health and Ageing, for the purposes of storage and subsequent retrieval, the record so made shall be deemed to be a retention of the request or confirmation. The production or reproduction of such a record shall be deemed to be a production of the written request or written confirmation.

An Approved Pathology Practitioner is required to produce, on request from an officer of Medicare Australia, no later than the end of the day following the request from the officer, a written request or written confirmation retained pursuant to the above paragraphs. The officer is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations.

PB.2.5 ***Offences in Relation to Retaining and Producing Request Forms***

The following offences are punishable upon conviction by a fine not exceeding $1000:

(i) an Approved Pathology Practitioner who, without reasonable excuse, does not keep request forms for 18 months;

(ii) an Approved Pathology Practitioner who, without reasonable excuse, does not produce a request form to an officer of Medicare Australia before the end of the day following the day of the officer's request.

PB.2.6 ***Referral From An Approved Pathology Practitioner To Another Approved Pathology Practitioner***

Where an Approved Pathology Practitioner refers some or all services requested to another Approved Pathology Practitioner not associated with the same Approved Pathology Authority the following apply:

(i) where all the services are referred, the first Approved Pathology Practitioner should forward the original request to the second Approved Pathology Practitioner, and the document bearing the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

(ii) where some of the services which are listed in different items in the Schedule are referred, the first Approved Pathology Practitioner must issue his/her own request in writing listing the tests to be performed, and when necessary, forward a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

in addition to the details of the first Approved Pathology Practitioner, the second Approved Pathology Practitioner must show on the account/receipt/assignment form:

(a) name and provider number of the original requesting practitioner; and

(b) date of original request;

(iii) under the item coning rules (which limit benefits for multiple services) only one Medicare benefit is payable for services included in coned items except for estimations covered by Rule 6 entitled "designated pathology services". The exemption allows payment of more than one Medicare benefit where various components of the one item number from the same request e.g. drug assays (items 66800 and 66812) are performed by two Approved Pathology Authorities.

Although the provisions concerning designated pathology services in Rule 6 permit similar services (e.g. hormone estimations) to be performed by 2 or more laboratories, with different Approved Pathology Authorities, the sum of the Medicare benefit payable for services provided by the laboratories concerned will not exceed the maximum amount payable under the item coning rules when a single laboratory performs all the estimations.

Notes:

(i) the patient should be billed by each Approved Pathology Practitioner only for those services rendered by or on his/her behalf;

(ii) photocopies of requests are not acceptable;

(iii) in the case of "designated pathology services" (i.e. items 66713, 66737, 66809, 66818 and 69402 only) a patient episode initiation fee (PEI) is payable for the services provided by the laboratory which receives the original request and performs one or more of the estimations. However, no PEI is payable for services provided by the other laboratory which performs the remainder of the estimations. A "specimen referred fee" is payable instead. One Approved Pathology Practitioner cannot claim both a PEI and a "specimen referred fee" in relation to the same patient episode.

PB.2.7 ***Offence Not To Confirm An Oral Request***

An Approved Pathology Practitioner who, without reasonable excuse, does not confirm in writing an oral request to another Approved Pathology Practitioner within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000, and the request is deemed never to have been made.

PB.3 Pathology Tests Not Covered by Request

An Approved Pathology Practitioner, who has been requested to perform one or more pathology services, may consider it necessary, in the interest of the patient, that additional tests to those requested be carried out. The Approved Pathology Practitioner must discuss this need with the requesting practitioner, and if the requesting practitioner determines that additional tests are necessary, the Approved Pathology Practitioner must arrange with the requesting practitioner to forward an amended or second request for those services. The account will then be issued in the ordinary way and the additional services will attract benefits providing the Approved Pathology Practitioner is a recognised specialist pathologist.

PC. DETAILS REQUIRED ON ACCOUNTS, RECEIPTS OR ASSIGNMENT FORMS

PC.1 General

Medicare benefit is not payable in respect of a pathology service unless specified details are provided, by the practitioner rendering the service, on his or her account, receipt or assignment form.

PC.2 Approved Pathology Practitioners

In addition to holding a request in writing from the treating medical or dental practitioner or from another Approved Pathology Practitioner, the following additional details must be recorded on the account, receipt or assignment form of the Approved Pathology Practitioner providing the service:

(i) the surname and initials of the Approved Pathology Practitioner who performed the service and either his/her practice address or the provider number for the address;

(ii) the name of the person to whom the service was rendered;

(iii) the date on which the service was rendered;

(iv) the name of the requesting practitioner;

(v) the date on which the request was made;

(vi) the requesting practitioner's provider number;

(vii) a description of the pathology service in words which are derived from the item description in the Schedule and are of sufficient detail to identify the specific test in the Schedule that was rendered.

Instead of such a full description, the abbreviations contained in the index and the group abbreviations listed at PQ.4 are acceptable alternatives (see PQ.1);

(viii) where the Approved Pathology Practitioner determines or provides a pathology service on his/her own patient, the account must be endorsed "sd"; and

(ix) provide collection centre identification number if the specimen was collected in a licensed collection centre (or approved pathology collection centre).

Where some services are referred from one Approved Pathology Practitioner to another Approved Pathology Practitioner, the request details to be shown on the second Approved Pathology Practitioner's account, receipt or assignment form must be identical to those of the original requesting practitioner including the date of request.

PC.3 Prescribed Pathology Services

For Prescribed Pathology Services (that is, pathology items in Group P9) the medical practitioner who renders the service must ensure his or her account, receipt or assignment form includes his or her name, address or provider number, the date of the service, and a description to clearly identify the service in the Schedule that was rendered.

If the service was determined necessary by another medical practitioner who is a member of the same group practice as the practitioner who rendered the service, the name of the requesting practitioner, sufficient to identify the practitioner from other practitioners in the same group practice with the same surname, must also be included together with the date on which the request was made.

PD. MULTIPLE SERVICES RULE

PD.1 Description of Rule

The term "Multiple Services Rule" (Rule 3 of the Pathology Services Table) describes an arrangement which places limits on the benefits payable for items in the Pathology Services Table depending on the range of services performed during a single patient episode. A patient episode is defined in PO.4 of these notes.

PD.2 Exemptions

Under Rule 4 of the Pathology Services Table, exemptions to the multiple services rule have been granted for certain specified tests. In some circumstances tests which are repeated up to 6 times over a 24 hour period, or tests which are requested up to 6 times on a single request form and are performed within 6 months of the date of request may be eligible for separate Medicare benefits. The services to which the exemptions apply are listed under Rule 4.(1 and 2) and cover seriously or chronically ill patients who require particular tests under specified circumstances. In order to claim the exemptions, accounts should be endorsed "Rule 3 Exemption".

Where a practitioner seeks an exemption to the multiple services rule for a patient whose condition requires a series of pathology investigations at various times throughout any one day or over a longer period of time, and the services required are not exempted under Rule 4, an application for exemption can be made which is endorsed "S4B(3)". Some factors that the delegate of the Minister may take into consideration in approving an exemption are: the patient is seriously ill; there are distinct and separate collections and performances of tests; and the services involve substantial additional expenses for the Approved Pathology Practitioner. These, and other clinical details, should be supplied by the practitioner when seeking an S4B(3) exemption.

If Rule 3 exemptions are endorsed "S4B(3)", claim assessment could take longer as all S4B(3) claims are passed to the delegate for assessment. S4B(3) covers all exemptions to the multiple services rule but, where applicable, specific "Rule 3 exemption" endorsements will speed up the payment of claims. Rule 3 and S4B(3) exemptions cannot be used to overcome time based restrictions within items e.g. "…. each test to a maximum of 4 tests in a 12 month period".

PE. EPISODE CONE

PE.1 Description of Rule 18

The term "Episode Cone" describes an arrangement under which Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised patient, will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Further information on the episode coning arrangements is provided in PO.5 of these notes.

PE.2 Exemptions

Some items are not included in the count of the items performed when applying episode coning. The items which have been exempted from the cone include all the items in Groups P10, P11 and P12, the Pap smear testing items (73053 and 73055), the designated pathology services items (66713, 66737, 66809, 66818 and 69402) and the supplementary test for Hepatitis B surface antigen or Hepatitis C antibody (69484).

PF. SCHEDULE FEES

PF.1 Single Level Fees

A single level Schedule fee as opposed to the previous SP and OP fee levels was introduced from 1 February 1992. The Schedule fee was set at 70% of the previous SP fee for all services except for a cytology item, a histopathology item and three high volume test items.

PF.2 Patient Episode Initiation Fees (PEIs)

Items in Groups P10 of the Pathology Services Table are only applicable to services performed:

(i) by or on behalf of an Approved Pathology Practitioner who is a recognised specialist pathologist; and

(ii) in private practice.

Accordingly, these fees are not payable for pathology services rendered by an Approved Pathology Practitioner, being a specialist pathologist when requested for a:

(i) privately referred out-patient of a recognised hospital;

(ii) private in-patient in a recognised hospital; or where

(a) any pathology equipment of a recognised hospital, or a laboratory included in a prescribed class of laboratories, is used; or

(b) any member of the staff of a recognised hospital, or a laboratory included in a prescribed class of laboratories, participates in the provision of the service in the course of his/her employment with that hospital or laboratory.

The patient episode initiation fees (PEIs) will be applicable on an episodic basis i.e. a claim may be made for the provision of pathology services requested by a practitioner in respect of one individual on the same day. For example, if a practitioner orders three pathology tests for a person on the one day, Medicare benefits will be payable for each of those tests but only one PEI will be applicable.

This Rule applies even when the treating practitioner has requested pathology tests from two or more Approved Pathology Practitioners. Thus a PEI will only be paid for the first account submitted unless an exemption listed in Rule 4 or 14.(7) applies or an exemption has been granted under "S4B(3)".

Under Rule 14.(7) two PEIs are payable in relation to the same patient episode where a referring practitioner refers two different specimens to two different Approved Pathology Authorities in the following circumstances:

. a tissue pathology specimen and any other non-tissue pathology specimen; or

. a cytopathology specimen and any other non-cytopathology specimen.

Rule 14.(8) also provides that only one PEI will be paid for the collection of specimens from a patient on one day in or by a single Approved Pathology Authority.

The patient episode initiation fees are two-tiered.

A higher fee will be payable for specimens collected in an approved collection centre, private hospital or day hospital facility where the patient is an in-patient. The specimen must be collected by an employee of the proprietor of the laboratory in which the pathology service will be rendered, or an Approved Pathology Practitioner associated with that laboratory.

A lower fee will be payable for specimens collected by the patient himself or herself or specimens collected by or on behalf of a treating practitioner.

PF.3 Patient Episode Initiation Fees for Certain Tissue Pathology and Cytology Items

Tissue Pathology items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 and Cytology items 73053, 73055 and 73057 will be subject to a different patient episode initiation fee structure - items 73901 to 73905 refer.

PF.4 Hospital, Government etc Laboratories

The following laboratories have been prescribed for the purposes of payment of Medicare benefits as outlined in paragraphs PF.2 and PF.3:

(i) laboratories operated by the Australian Government (these include health laboratories operated by the Australian Government Department of Health and Ageing as well as the laboratories operated by other Departments, e.g. the Departments of Defence and Veterans' Affairs operate laboratories from which pathology services are provided);

(ii) laboratories operated by a State Government or authority of a State (laboratories operated or associated with recognised hospitals are also included);

(iii) laboratories operated by the Northern Territory and the Australian Capital Territory; and

(iv) laboratories operated by Australian tertiary education institutions eg Universities.

PG. ASSIGNMENT OF MEDICARE BENEFITS

PG.1 Patient Assignment

In addition to the general arrangements relating to the assignment of benefits, as outlined at paragraph 7 of the "General Explanatory Notes" in Section 1 of this book, it should be noted that, where the treating practitioner requests pathology services but the patient does not physically attend the Approved Pathology Practitioner, the patient may complete an assignment voucher at the time of the visit to the requesting doctor offering to assign benefits for the Approved Pathology Practitioner's services.

If an Approved Pathology Practitioner refers some of the tests requested by the treating practitioner to another Approved Pathology Authority, he/she should provide the second Approved Pathology Authority with a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can also direct-bill Medicare.

PG.2 Approved Pathology Practitioner Eligibility

If a practitioner requests an Approved Pathology Practitioner to perform a necessary pathology service, that Approved Pathology Practitioner must personally perform the service or have it performed on his/her behalf in order to be eligible to receive benefits by way of assignment. If, however, the first Approved Pathology Practitioner arranges for the service to be rendered by a second Approved Pathology Practitioner with the same Approved Pathology Authority, the second Approved Pathology Practitioner and not the first, is eligible to receive an assignment of the Medicare benefit for the service in question.

PH. ACCREDITED PATHOLOGY LABORATORIES

PH.1 Need For Accreditation

A pathology service will not attract Medicare benefits unless that service is provided in a pathology laboratory which is accredited for that kind of service. Details of the administration of the pathology laboratory accreditation arrangements are set out below.

PH.2 Applying For Accreditation

To become an Accredited Pathology Laboratory it is necessary to lodge a completed application form with the Manager, Pathology Section, Medicare Australia, PO Box 1001, TUGGERANONG ACT 2901. The prescribed fees for Approved Pathology Laboratories are:

- $2500 for Category GX labs
- $2000 for Category GY labs

- $1500 for Category B labs
- $ 750 for Category M & S labs.

It is necessary for an application for inspection be made to the National Association of Testing Authorities (NATA) NATA is the independent body chosen to act on the Australian Government's behalf as the primary inspection agency. The Royal Australian College of General Practitioners (RACGP) has also been appointed to inspect laboratories in Category M (general practitioner) in Victoria only.

Details of laboratory categories and associated supervisory requirements can be found on the Department's internet site (www.health.gov.au/pathology).

PH.3 Effective Period of Accreditation

Accreditation takes effect from the date of approval by the Minister for Health and Ageing. The Minister has no power to backdate an approval. Transitional accreditation may be given pending full accreditation. An application and fee are required annually.

PH.4 Assessment of Applications for Accreditation

The principles of accreditation for pathology laboratories as determined by the Minister are used to assess applications for accreditation. These principles also require pathology laboratories to address National Pathology Accreditation Advisory Council standards. Copies of the principles and standards are available from the Secretariat, National Pathology Accreditation Advisory Council (see PH.6) on (02) 6289 4017 or email npaac@health.gov.au.

PH.5 Refusal of Accreditation and Right of Review

An applicant who has been notified of the intention to refuse accreditation may, within 28 days of being notified, provide further information to the Minister which may be taken into consideration prior to a final decision being made.

Applicants refused accreditation or any person affected by the decision have the right to appeal to the Administrative Appeals Tribunal.

PH.6 National Pathology Accreditation Advisory Council (NPAAC)

NPAAC was established in 1979. Its functions are to develop policy for accreditation of pathology laboratories, introduce and maintain uniform standards of practice in pathology services throughout Australia and initiate and coordinate educational programs in relation to pathology practice. The agencies used to inspect laboratories on the Australian Government's behalf are required to conduct inspections using the standards set down by NPAAC. For further information the NPAAC Secretariat can be contacted on (02) 6289 4017 or email npaac@health.gov.au.

PH.7 Change of Address/Location

Laboratories are accredited for the particular premises given on the application form. Where a laboratory is relocated to other premises, any previously issued approvals for that Accredited Pathology Laboratory lapse. Medicare benefits are not payable for any pathology services performed at the new location until a new application has been approved by the Minister for Health and Ageing. Paragraph PH.2 sets out the method for applying for accreditation.

PH.8 Change of Ownership of a Laboratory

Part of the assessment of an application for an Accredited Pathology Laboratory relates to the Approved Pathology Authority status. Where the ownership, or some other material change occurs affecting the laboratory, the Minister for Health and Ageing must be provided with those changed details. Medicare benefits will not be payable for any pathology services performed on any premises other than those premises for which approval has been given.

PH.9 Approved Collection Centres (ACC)

New arrangements for specimen collection centres commenced on 1 December 2001 and replaced the Licensed Collection Centre (LCC) Scheme.

These arrangements were fully implemented on 1 July 2005 following a transition period of over four years to allow the pathology sector to adjust to a less regulated environment.

To enable the payment of Medicare benefits for pathology services performed on pathology specimens collected in a collection centre, the centre must first be approved. The exception to this rule is collection centres on the premises of recognised hospitals (recognised hospital in this context means the same as "recognized hospital" in Part 1 Section 3 of the Health Insurance Act 1973) as they do not need approval.

The number of collection centres an Approved Pathology Authority can operate under Medicare is primarily determined on the basis of its Medicare and Department of Veterans' Affairs pathology activity.

In order for a collection centre to be approved, a public or private Approved Pathology Authority must submit a completed application form to Medicare Australia including details of the type of application (renewal, new or cancellation of collection centre), the location of the premises, the owner, and any leasing arrangements.

Application forms can be accessed by going to Medicare Australia website www.medicareaustralia.gov.au**.** Completed application forms and any enquiries should be forwarded to the Manager, Pathology Section, Medicare Australia, PO Box 1001, TUGGERANONG ACT 2901.

PI. APPROVED PATHOLOGY PRACTITIONERS

PI.1 Introduction

A pathology service will not attract Medicare benefits unless that service is provided by or on behalf of an Approved Pathology Practitioner. (Approved Pathology Practitioners must be registered medical practitioners.) Set out below is information which relates to Approved Pathology Practitioner requirements.

PI.2 Applying for Acceptance of the Approved Pathology Practitioner Undertaking

To apply for acceptance of an Approved Pathology Practitioner Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Practitioner Undertaking; and

(ii) a signed Approved Pathology Practitioner Undertaking to the Pathology Registration Co-ordinator, Medicare Australia, PO Box 9822 (in your capital city).

An application form, undertaking and associated literature can be obtained from the Pathology Registration Co-ordinator.

PI.2.1 *Payment of Acceptance Fee*

On receipt of advice that the Minister has accepted an undertaking, a cheque for $500 should be despatched to the Pathology Registration Co-ordinator. Applicants are required to pay this fee within 14 days of the notice being given (ie. the day the notice is sent).

As there is no discretion under the *Health Insurance Act 1973* to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;

(ii) a new application must be completed;

(iii) acceptance of the new undertaking cannot be backdated; and

(iv) there will therefore be a period during which Medicare benefits cannot be paid.

PI.2.2 *Reminder Process*

In administering the Approved Pathology Authority and Approved Pathology Practitioner arrangements, Medicare Australia provides reminders to ensure that:

(i) applicants whose undertaking are about to expire are aware of the consequences of late lodgement; and

(ii) where the 14 day period for payment of fees is about to expire and the fees have not been paid, that applicants are aware of the consequences of failure to pay on time.

PI.3 Undertakings

PI.3.1 *Consideration of Undertakings*

The Minister is unable to accept an undertaking from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, amongst other things, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Practitioner.

When an undertaking has been given, the Minister may require the person giving the undertaking to provide additional information within a fixed period of time and if the person does not comply the Minister may refuse to accept the undertaking.

PI.3.2 *Refusal of Undertaking and Rights of Review*

Where the Minister refuses to accept an undertaking, for any of the reasons shown above, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

PI.3.3 *Effective Period of Undertaking*

The following applies:

(i) Date of Effect - the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect - in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving undertakings of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals - when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by Medicare Australia until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

(iv) Cessation of Undertaking - the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires - whichever event first occurs.

An Approved Pathology Practitioner may terminate an undertaking at any time providing that the practitioner gives at least 30 days notice of his/her intention to do so.

PI.4 Obligations and Responsibilities of Approved Pathology Practitioners

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Practitioners and the Minister. The more complex of these not already dealt with are considered in PK, PL and PM dealing with Breaches of Undertakings, Excessive Pathology Services and Personal Supervision.

PJ. APPROVED PATHOLOGY AUTHORITIES

PJ.1 Introduction

A pathology service will not attract Medicare benefits unless the proprietor of the laboratory in which the pathology service is performed is an Approved Pathology Authority. Following is information which relates to Approved Pathology Authority requirements.

PJ.2 Applying for Acceptance of an Approved Pathology Authority Undertaking

To apply for acceptance of an Approved Pathology Authority Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Authority Undertaking; and

(ii) a signed Approved Pathology Authority Undertaking.

to the Manager Pathology Section, Health Insurance Section, PO Box 1001, Tuggeranong ACT 2901. Application forms, undertakings and associated literature can be obtained from the Pathology Registration Co-ordinator.

The application and the undertaking should be completed by the proprietor of the laboratory/ies and where the proprietor is not a natural person (e.g. company or partnership), an authorised representative/s should complete the forms. This proprietor can be:

(i) a natural person;

(ii) partners (natural persons and/or companies) in a partnership;

(iii) a body corporate (i.e. a company); or

(iv) a government authority (e.g. a public hospital).

PJ.2.1 *Payment of Acceptance Fee*

On receipt of advice that the Minister has accepted an undertaking, a cheque for $1,500 should be dispatched within 14 days or the undertaking will be cancelled and the whole process begun again with a consequent gap in the payment of benefits.

PJ.3 Undertakings

PJ.3.1 *Consideration of Undertakings*

The Minister is unable to accept undertakings from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, inter alia, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Authority.

When an undertaking has been given the Minister may require the person giving the undertaking to provide additional information within a specified period of time and if the person does not comply the Minister may refuse to accept the undertaking.

PJ.3.2 *Refusal of Undertaking and Rights of Review*

Where the Minister refuses to accept an undertaking, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

PJ.3.3 ***Effective Period of Undertaking***

The following applies:

(i) Date of Effect - the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect - in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving an undertaking of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals - when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by the Health Insurance Commission until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

(iv) Cessation of Undertaking - the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires - whichever event first occurs.

An Approved Pathology Authority may terminate an undertaking at any time providing that at least 30 days notice of the intention to terminate the undertaking is given.

PJ.4 Obligations and Responsibilities of Approved Pathology Authorities

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Authorities and the Minister. The more complex of these which have not already been covered are considered in paragraphs PK and PL dealing with Breaches of Undertakings and Excessive Pathology Services.

PK. BREACHES OF UNDERTAKINGS

PK.1 Notice Required

Where the Minister has reasonable grounds for believing that an Approved Pathology Practitioner or an Approved Pathology Authority has breached the undertaking, the Minister is required to give notice in writing to the person explaining the grounds for that belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PK.2 Decisions by Minister

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively the Minister may refer the matter to a Medicare Participation Review Committee, notifying the grounds for believing that the undertaking has been breached. If after 28 days no submission has been received from the person, the Minister must refer that matter to the Committee.

PK.3 Appeals

The Minister is empowered to suspend an undertaking where notice has been given to a Medicare Participation Review Committee of its possible breach, pending the outcome of the Committee's proceedings. The Minister must give notice in writing to the person who provided the undertaking of the determination to suspend it, and the notice shall inform the person of a right of appeal against the determination to the Administrative Appeals Tribunal. The Minister may also publish a notice of a determination in the Public Service Gazette. Rights of appeal to the Administrative Appeals Tribunal also exist in respect of any determination made by a Medicare Participation Review Committee.

PL. INITIATION OF EXCESSIVE PATHOLOGY SERVICES

PL.1 Notice Required

Where the Minister has reasonable grounds for believing that a person, of a specified class of persons, has initiated, or caused or permitted the initiation of excessive pathology services the Minister is required to give notice in writing to the person explaining the grounds for the belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PL.2 Classes of Persons

The classes of persons are:

(i) the practitioner who initiated the services;

(ii) the employer of the practitioner who caused or permitted the practitioner to initiate the services; or

(iii) an officer of the body corporate employing the practitioner who caused or permitted the practitioner to initiate the services.

PL.3 Decisions by Minister for Health and Ageing

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively, the Minister may refer the matter to a Professional Services Review (PSR) Committee, notifying the grounds for believing that excessive pathology services have been initiated. If after 28 days no submission has been received from the person, the Minister must refer the matter to the Committee. The Minister must give to the person notice in writing of the decision.

PL.4 Appeals

Unlike the procedures relating to breaches of undertaking there is no power given to the Minister to determine a penalty. The Minister's role is either deciding to take no further action or referring the matter to a PSR Committee. Accordingly, there are no rights of appeal to the Administrative Appeals Tribunal applicable to the above procedures. However, rights of appeal to the Administrative Appeals Tribunal exist in respect of any determination made by a Medicare Participation Review Committee.

PM. PERSONAL SUPERVISION

PM.1 Introduction

The *Health Insurance Act 1973* provides that the form of undertaking to be given by an Approved Pathology Practitioner may make provision for pathology services carried out under the personal supervision of the Approved Pathology Practitioner.

PM.2 Extract from Undertaking

The following is an extract from the Approved Pathology Practitioner (APP) undertaking:

Part 2 – Personal supervision

2.1 I acknowledge that it is my obligation, subject to Parts 2.2 and 2.4, personally to supervise any person who renders any service on my behalf and I undertake to accept personal responsibility for the rendering of that service under the following conditions of personal supervision:

(i) Subject to the following conditions, I will usually be physically available in the laboratory while services are being provided at the laboratory;

(ii) I may, subject to paragraph (vi) below, be physically absent from the laboratory while services are being rendered outside its normal hours of operation but in that event I will leave with the person rendering the service particulars of the manner in which I may be contacted while the service is being rendered and I must be able to personally attend at the laboratory while the service is being rendered or formally designate another APP present while I am absent;

(iii) I may, subject to paragraph (vi) below, be absent from the laboratory for brief periods due to illness or other personal necessity, or to take part in activities which, in accordance with normal and accepted practice, relate to the provision of services by that laboratory;

(iv) I will personally keep a written log of my absences from the laboratory that extend beyond one workday

in respect of that laboratory and will retain that log in the laboratory for 18 months from date of last entry;

(v) If I am to be absent from the laboratory for more than 7 consecutive workdays, I will arrange for another APP to personally supervise the rendering of services in the laboratory. That arrangement shall be recorded in writing and retained in the laboratory for 18 months from date of last entry. Until such person is appointed, and his or her appointment is recorded in writing, I will remain personally responsible to comply with this undertaking;

(vi) If a service is being rendered on my behalf by a person who is not:
(a) a medical practitioner;
(b) a scientist; or
(c) a person having special qualifications or skills relevant to the service being rendered;
and no person in the above groups is physically present in the laboratory, then I must be physically present in the laboratory and closely supervise the rendering of the service;

(vii) I accept responsibility for taking all reasonable steps to ensure that in regard to services rendered by me or on my behalf:
(a) all persons who render services are adequately trained;
(b) all services which are to be rendered in the laboratory are allocated to persons employed by the APA and, these persons shall have appropriate qualifications and experience to render the services;
(c) the methods and procedures in operation in the laboratory for the purpose of rendering services are in accordance with proper and correct practices;
(d) for services rendered, proper quality control methods are established and reviewed to ensure their reliability and effectiveness; and
(e) Results of services and tests rendered are accurately recorded and sent to the treating practitioner and, where applicable, a referring practitioner;

(viii) If I perform, or there is performed on my behalf, a service which consists of the analysis of a specimen which I know, or have reason to believe, has been taken other than in accordance with the provisions of section 16A(5AA) of the Act I will endorse, or cause to be endorsed, on the assignment form or the account for that service, as the case may be, particulars of the circumstances in which I believe, or have reason to believe, the specimen was taken.

2.2 Where services are to be rendered on my behalf in a Category B laboratory as defined in the *Health Insurance (Accredited Pathology Laboratories – Approval) Principles 2002*, I undertake to take all reasonable measures to ensure that the service is rendered under the supervision of an appropriate person as required by those Principles as in force from time to time.

2.3 I acknowledge to the best of my ability that any act or omission by a person, when acting with my authority, whether express or implied, that would, had it been done by me, have resulted in a breach of this undertaking, constitutes a breach of this undertaking by me.

2.4 Parts 2.1(i) to 2.1(vi) and 2.2 of this undertaking do not apply where a laboratory is limited to services (and associated equipment for those services) as detailed in Schedule 3.

PM.3 Notes on the Above

Part 2 of the APP Undertaking outlines the requirements for the personal supervision by an Approved Pathology Practitioner where a pathology service is rendered by another person on behalf of the APP. It should be noted that "on behalf of" does not relieve an Approved Pathology Practitioner of professional responsibility for the service or from being personally involved in the supervision of services in the laboratory.

PN. CHANGES TO THE PATHOLOGY SERVICES TABLE

PN.1 Health Insurance Regulations

The *Health Insurance Act 1973* allows the Minister for Health and Ageing to determine an appropriate Pathology Services Table which is then prescribed by Regulation.

The Minister has established the Pathology Services Table Committee (PSTC) to assist in determining changes to the Table (except new medical services and technologies - see below). Any person or organisation seeking to make a submission to this Committee can contact the PSTC Secretariat on (02) 6289 4081 or e-mail pstc@health.gov.au and/or write to: Secretary, PSTC, MDP 107, Department of Health and Ageing, GPO Box 9848, CANBERRA ACT 2601.

Pathology submissions relating to new medical services and technologies should be forwarded to the Medical Services Advisory Committee (MSAC). MSAC has been established to advise the Minister on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported.

Any person or organisation seeking to make a submission to MSAC can contact the MSAC Secretariat on (02) 6289 6811 or email msac.secretariat@health.gov.au and/or write to: Director, Strategic Policy Section, Department of Health and Ageing, GPO Box 9848, CANBERRA ACT 2601. The application form and guidelines for applying can also be obtained from MSAC's website – www.msac.gov.au

PART TWO - EXPLANATORY NOTES

PO. DEFINITIONS

PO.1 Excessive Pathology Service

This means a pathology service for which a Medicare benefit has become or may become payable and which is not reasonably necessary for the adequate medical or dental care of the patient concerned.

PO.2 Group of Practitioners

This means:

(i) a practitioner conducting a medical practice or a dental practice together with another practitioner, or other practitioners, participating (whether as employees or otherwise) in the provision of professional services as part of that practice; or

(ii) two or more practitioners conducting a medical practice or a dental practice as partners; or

(iii) those partners together with any other practitioner who participates (whether as an employee or otherwise) in the provision of professional services as part of that practice.

PO.3 Initiate

In relation to a pathology service this means to request the provision of pathology services for a patient.

PO.4 Patient Episode

A patient episode comprises a pathology service or services specified in one or more items which are provided for a single patient, the need for which was determined under subsection 16A(1) of the Act on the same day, whether they were provided by one or more approved pathology practitioners on one day or over several days and whether they are requested by one or more treating practitioners. Even if a treating practitioner writes separate request forms to cover the collection of specimens at different times, where the decision to collect the multiple specimens was made at the same time, the multiple tests are deemed to belong to the same patient episode. In addition, if more than one request is made, on the same or different days, for tests on the same specimen within 14 days, they are part of the same patient episode.

Rule 4 of the Pathology Services Table provides an exemption to the above and enables services requested on one day which are performed under strictly limited circumstances for seriously or chronically ill patients with certain specified conditions to each be classified as a patient episode. See PD.2 for further information on exemptions.

Rule 14.(8) also provides that only a single patient episode initiation fee will be payable for all the specimens collected on one day from one patient in or by one Approved Pathology Authority.

PO.5 Episode Cone

The episode cone is an arrangement, described in Rule 18, which effectively places an upper limit on the number of items for which Medicare benefits are payable in a patient episode. This cone only applies to services requested by general practitioners for their non-hospitalised patients. Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.

When more than 3 items are requested by a general practitioner in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Rule 18 provides that for the two items with the highest Schedule fees, Medicare benefits will be payable for each item. The remaining items are regarded as one service for

which the benefit payable will be equivalent to that for the item with the third highest Schedule fee. Where items have the same Schedule fee, their item numbers are used as an artificial means to rank them.

The episode cone will apply even when the pathology services in a patient episode are performed by 2 or more Approved Pathology Authorities, with the exception of the services listed below.

The following items are not included in the count of the items performed when applying the episode cone:

(i) all the items in Groups P10, P11 and P12;

(ii) Pap smear testing (items 73053 and 73055);

(iii) designated pathology services (items 66713, 66737, 66809, 66818 and 69402); and

(iv) supplementary test for Hepatitis B and Hepatitis C (item 69484).

PO.6 Personal Supervision

This means that an Approved Pathology Practitioner will, to the fullest extent possible, be responsible for exercising an acceptable level of control over the rendering of pathology services. See PM.1 to PM.3 for a full description of the responsibilities involved in personal supervision.

PO.7 Prescribed Pathology Service

These are simple basic pathology services which are included in Group P9 and may be performed by a medical practitioner in the practitioner's surgery without the need to obtain Approved Pathology Authority, Approved Pathology Practitioner or Accredited Pathology Laboratory status.

PO.8 Proprietor of a Laboratory

This means in relation to a pathology laboratory the person, authority or body of persons having effective control of:

(i) the laboratory premises, whether or not the holder of an estate or interest in the premises;

(ii) the use of equipment used in the laboratory; and

(iii) the employment of staff in the laboratory.

PO.9 Specialist Pathologist

This means a medical practitioner recognised for the purposes of the *Health Insurance Act 1973* as a specialist in pathology (see 5.1 of the "General Explanatory Notes" in Section 1 of this book). The principal specialty of pathology includes a number of sectional specialties. Accordingly, a medical practitioner who is recognised as a specialist in a sectional specialty of pathology is recognised as a specialist pathologist for this purpose.

PO.10 Designated Pathology Service

This means a pathology service specified in items 66713, 66737 66809, 66818 and 69402. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some but not all the estimations in a coned item and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the rest, the service provided by the second practitioner is deemed to be the "designated pathology service". Thus the first practitioner claims under the appropriate item for the services which he/she provides while the second practitioner claims one of items 66713, 66737, 66809, 66818 or 69402. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some, but not all estimations and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the remainder, the first Approved Pathology Practitioner can raise a "patient episode initiation fee". The second Approved Pathology Practitioner who receives the specimen can raise a "specimen referred fee".

PP. INTERPRETATION OF THE SCHEDULE

PP.1 Faecal Occult Blood (Items 66764 - 66770)

The fee for items 66764-66770 is only payable where both test methods described in the item have been performed.

PP.2 Tissue Pathology and Cytology (Items 72813 - 73061)

When services described in Group P5 need to be performed upon material which is submitted for cytology items listed in Group P6 only the fee for the P6 item can be claimed.

PP.3 Cervical and Vaginal Cytology (Items 73053 - 73057)

Item 73053 applies to the cytological examination of cervical smears collected from women with no symptoms, signs or recent history suggestive of cervical neoplasia as part of routine, biennial examination for the detection of pre-cancerous or cancerous changes. This item also applies to smears repeated due to an unsatisfactory routine smear, or if there is inadequate information provided to use item 73055.

Cytological examinations carried out under item 73053 should be in accordance with the agreed National Policy on Screening for the Prevention of Cervical Cancer. This policy provides for:

(i) an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one to two years after first sexual intercourse, whichever is later; and

(ii) cessation of cervical smears at 70 years for women who have had two normal results within the last five years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

This policy has been endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, The Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council.

The *Health Insurance Act 1973* excludes payment of Medicare benefits for health screening services except where Ministerial directions have been issued to enable benefits to be paid, such as the Papanicolaou test. As there is now an established policy which has the support of the relevant professional bodies, routine screening in accordance with the policy will be regarded as good medical practice.

The screening policy will not be used as a basis for determining eligibility for benefits. However, the policy will be used as a guide for reviewing practitioner profiles.

Item 73055 applies to cervical cytological examinations where the smear has been collected for the purpose of management, follow up or investigation of a previous abnormal cytology report, or collected from women with symptoms, signs or recent history suggestive of abnormal cervical cytology.

Items 73057 applies to all vaginal cytological examinations, whether for a routine examination or for the follow up or management of a previously detected abnormal smear.

For cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, by item number, if the smear has been taken as a routine examination or for the management of a previously detected abnormality.

PP.4 Eosinophil Cationic Protein (Item 71095)

Item 71095 applies to children aged less than 12 years who cannot be reliably monitored by spirometry or flowmeter readings.

PP.5 Additional bulk billing payment for pathology services (item 74990 and 74991)

Item 74990 operates in the same way as item 10990 and item 74991 operates in the same way as item 10991 (see explanatory note M.1), apart from the following differences:

- Item 74990 and 74991 can only be used in conjunction with items in the Pathology Services Table of the MBS;
- Item 74990 and 74991 applies to unreferred pathology services performed by a medical practitioner which are included in Group P9 of the Pathology Services Table, and unreferred pathology services provided by category M laboratories;
- Item 74990 and item 74991 applies to pathology services self determined by general practitioners and specialists with dual qualifications acting in their capacity as general practitioners;
- Specialists and consultant physicians who provide pathology services are not able to claim item 74990 or item 74991 unless, for the purposes of the Health Insurance Act, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to that practitioner by another medical practitioner or person

with referring rights.

Rules 3 and 18 of the *Health Insurance (Pathology Services Table) Regulations 2003* have been amended to exclude item 74990 and 74991 from the Multiple Services Rule and the Coning Rule.

Item 74991 can only be used where the service is provided at, or from, a practice location in a regional, rural or remote area (RRMA 3 to 7 under the Rural Remote Metropolitan Areas classification system), or in all of Tasmania.

PP.6 Antibiotics/Antimicrobial Chemotherapeutic Agents

A test for the quantitation of antibiotics/antimicrobial chemotherapeutic agents is claimable under item 66800 or 66812 - 'quantitation of a drug being used therapeutically'.

PP.7 Items referring to the 'detection of'

Items that contain the term 'detection of' should be taken to mean 'testing for the presence of'.

PP.8 Blood Grouping (Item 65096)

Where a request includes 'Group and Hold' or 'Group and Save', the appropriate item is 65096.

PP.9 Iron Studies (Item 66596)

Where a request includes 'Iron Studies', 'IS', 'Fe', '% saturation' or 'Iron', the relevant item is 66596.

PP.10 Glycosylated haemoglobin (Item 66551)

The requirement of "established diabetes" in this item may be satisfied by:

a) a statement of the diagnosis by the ordering practitioner on the current request form or on a previous request form held in the database of the Approved Pathology Authority; or

b) two or more blood glucose levels that are in the diabetic range and is contained in the database of the Approved Pathology Authority; or

c) an oral glucose tolerance test result that is in the diabetic range and is contained in the database of the Approved Pathology Authority.

PP.11 Hepatitis (Item 69481)

Benefits for item 69481 are payable only if the request from the ordering practitioner indicates in writing that the patient is suspected of suffering from acute or chronic hepatitis; either by the use of the provisional diagnosis of hepatitis or by relevant clinical or laboratory information eg "hepatomegaly", "jaundice" or "abnormal liver function tests".

PP.12 Fragile X (A) Tests (Items 73300 and 73305)

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

PP.13 Human Immunodeficiency Virus (HIV) Diagnostic Tests (included in items 69384, 69387, 69390, 69393, 69396, 69399, 69402, 69405, 69408, 69411, 69413, 69415)

Prior to ordering an HIV diagnostics tests (included in items 69384, 69387, 69390, 69393, 69396, 69399, 69402, 69405, 69408, 69411, 69413, 69415) the ordering practitioner should ensure that the patient has given informed consent. Appropriate counselling should be provided to the patient. Further counselling may be necessary upon receipt of the test results.

PQ. ABBREVIATIONS, GROUPS OF TESTS

PQ.1 Abbreviations

As stated at PC.2 of the Outline, details that must be recorded on accounts, receipts or assignment forms of an Approved Pathology Practitioner/Authority include a description of the pathology service that is of sufficient detail to identify the specific service rendered. The lists of abbreviations for group tests are contained in PQ.4. The lists of abbreviations for

individual tests are contained in the Index to this Section. The abbreviations are provided to allow users to identify and refer to particular pathology services, or particular groups of pathology services, more accurately and conveniently.

The above requirements may be used for billing purposes but treating practitioners requesting pathology services are encouraged to use the approved abbreviations. In this regard treating practitioners should note that:

- pathology services cannot be self determined by a rendering pathologist responding to a request. This places the onus for medical necessity on the treating practitioner who, in normal circumstances would, if he or she was unclear in deciding the appropriate test for a clinical situation, consult a pathologist for assistance; and
- Approved Pathology Practitioners/Authorities undertake not to issue accounts etc unless the pathology service was rendered in response to an unambiguous request.

PQ.2 Tests not Listed

Tests which are not listed in the Pathology Services Table do not attract Medicare benefits. As explained at PN.1 of the Outline, changes to the Pathology Services Table can only be made by the Minister for Health and Ageing.

PQ.3 Audit of Claims

Medicare Australia is undertaking routine audits of claims for pathology benefits against requested services to ensure compliance with the provisions of the *Health Insurance Act 1973*.

PQ.4 Groups of Tests

For the purposes of recording a description of the pathology service on accounts etc, an Approved Pathology Practitioner /Authority may use group abbreviations or group descriptions for the following specified groups of tests. These groups consist of two or more tests within the same item. These groups exclude abbreviations such as MBA and TORCH.

Treating practitioners are encouraged to use these group abbreviations or group descriptions where appropriate.

For ease of identification of group tests, it is recommended that practitioners use the following abbreviations. Tests requested individually may attract Medicare benefits.

Group	Estimations Included in Group	Group Abbreviation	Item Numbers
Cardiac enzymes or cardiac markers	Creatine kinase isoemzymes, myoglobin, troponin	CE / CM	66518, 66519
Coagulation studies	Full blood count, Prothrombin time, activated partial thrombo-plastin time and two or more of the following tests- fibrinogen, thrombin clotting time, fibrinogen degradation products, fibrin monomer, D-dimer factor XIII screening tests	COAG	65129, 65070
Electrolytes	Sodium (NA) potassium (K) chloride (CL) and bicarbonate (HCO3)	E	66509
Full Blood Examination	Erythrocyte count Haematocrit Haemoglobin Platelet count Red cell count Leucocyte count Manual or instrument generated differential Morphological assessment of blood film where appropriate	FBE, FBC, CBC	65070

Lipid studies	Cholesterol (CHOL) and triglycerides (TRIG)	FATS	66503
Liver function tests	Alkaline phosphatase (ALP), alanine aminotransferase (ALT), aspartate aminotransferase (AST), albumin (ALB), bilirubin (BIL), gamma glutamyl transpeptidase (GGT), lactate dehydrogenase (LDH), and protein (PROT).	LFT	66515
Syphilis serology	Rapid plasma reagin test (RPR), or venereal disease research laboratory test (VDRL), and treponema pallidum haemagglutin test (TPHA), or fluorescent treponemal antibody-absorption test (FTA)	STS	69387
Urea, electrolytes, creatinine	Urea, electrolytes, creatinine	U&E	66515

PR. COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

PR.1 Complexity Levels

Only one of these histopathology examination items (72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836) can be claimed in a patient episode.

The remaining items (72844, 72846, 72847, 72848, 72851, 72852, 72855, 72856 and 72857) are add-on items, covering enzyme histochemistry and immunohistochemistry, electron microscopy and frozen sections, which can be claimed in addition to the main item.

The list of complexity levels by type of specimen are contained at the back of this Section.

PX. PATHOLOGY SERVICES TABLE

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

1. (1) In this table

patient episode means:

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

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

whether the services:

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

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

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

serial examinations means a series of examinations requested on 1 occasion whether or not:
(a) the materials are received on different days by the approved pathology practitioner; or
(b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner.

***the* Act** means the *Health Insurance Act 1973.*

1. (2) In these rules, a reference to a request to an approved pathology practitioner includes a reference to a request for a pathologist-determinable service to which subsection 16A (6) of the Act applies.

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

1. (4) A reference to a **Group** in the table includes every item in the Group and a reference to a **Subgroup** in the table includes every item in the Subgroup.

Precedence of items

2. (1) If a service is described:
(a) in an item in general terms; and
(b) in another item in specific terms;
only the item that describes the service in specific terms applies to the service.

2. (2) Subject to subrule (3), if:
(a) subrule (1) does not apply; and
(b) a service is described in 2 or more items;
only the item that provides the lower or lowest fee for the service applies to the service.

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

Application of item 74990 and 74991

2. (4) Despite subrules (1), (2) and (3):
(a) if the pathology service described in item 74991 is provided to a person, either that item or item 74990, but not both those items, applies to the service; and
(b) if item 74990 or 74991 applies to a pathology service, the fee specified in that item applies in addition to the fee specified in any other item in the table that applies to the service.

2. (5) For items 74990 and 74991:
bulk-billed, in relation to a pathology service, means:
(a) a medicare benefit is payable to a person in respect of the service; and
(b) under an agreement entered into under section 20A of the Act:
(i) the person assigns to the practitioner by whom, or on whose behalf, the service is provided, his or her right to the payment of the medicare benefit; and
(ii) the practitioner accepts the assignment in full payment of his or her fee for the service provided.
Commonwealth concession card holder means a person who is a concessional beneficiary within the meaning given by subsection 84 (1) of the *National Health Act 1953*.
unreferred service means a pathology service that:
(a) is provided to a person by, or on behalf of, a medical practitioner, being a medical practitioner who is not a consultant physician, or specialist, in any speciality (other than a medical practitioner who is, for the purposes of the Act, both a general practitioner and a consultant physician, or specialist, in a particular speciality); and
(b) has not been referred to the medical practitioner by another medical practitioner or person with referring rights.

2. (6) For item 74991:

ASGC means the document titled Australian Standard Geographical Classification (ASGC) 2002, published by the Australian Bureau of Statistics, as in force on 1 July 2002.

practice location, in relation to the provision of a pathology service, means the place of practice in respect of which the practitioner by whom, or on whose behalf, the service is provided, has been allocated a provider number by the Commission**.**

Regional, rural or remote area means an area classified as RRMAs 3-7 under the Rural, Remote and Metropolitan Areas Classification.

Rural, Remote and Metropolitan Areas Classification has the meaning given by subrule 3 (1) of Part 2 of Schedule 1 to the general medical services table**.**

SLA means a Statistical Local Area specified in the ASGC.

SSD mean a Statistical Subdivision specified in the ASGC.

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

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

3. (2) Two or more pathology services (other than services to which, under rule 4, this rule does not apply) rendered for a patient following 2 or more requests are taken to have been rendered following a single request if:

(a) the services are listed in the same item; and
(ab) that item is not item 74990 or 74991; and
(b) the patient's need for the services was determined under subsection 16A (1) of the Act on the same day even if the services are rendered by an approved pathology practitioner on more than one day.

Services to which rule 3 does not apply

4. (1) Rule 3 does not apply to a pathology service described in item 65060, 65070, 65120, 65123, 65126, 65129, 65150, 65153, 65156, 66500, 66503, 66506, 66509, 66512, 66515, 66584 or 66800, if:

(a) the service is rendered in relation to one or more specimens taken on each of not more than 6 separate occasions in a period of 24 hours; and
(b) the service is rendered to an inpatient in a hospital; and
(c) each service must be rendered as soon as possible after collection and after authorization of the result of the previous specimen; and
(d) the account for the service is endorsed 'Rule 3 Exemption'.

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

(a) estimation of prothrombin time (INR) in respect of a patient undergoing anticoagulant therapy;
(b) quantitative estimation of lithium in respect of a patient undergoing lithium therapy;
(c) a service described in item 65070 in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;
(d) a service described in item 65070 in relation to clozaril, ticlopidine hydrochloride, methotrexate, gold, sulphasalazine or penicillamine therapy of a patient;
(e) a service described in item 66500 - 66515 in relation to methotrexate or leflunomide therapy of a patient;
(f) quantitative estimation of urea, creatinine and electrolytes in relation to:
  (i) cis-platinum or cyclosporin therapy of a patient; or
  (ii) chronic renal failure of a patient being treated in a dialysis program conducted by a recognised hospital;
(g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;

if:

(h) under a request for a service, other than a request for a service described in paragraph (a), no more than 6 tests are requested; and
(i) the tests are performed within 6 months of the request; and
(j) the account for the service is endorsed "Rule 3 Exemption".

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

5. (1) For an item in Group P1 (Haematology):

(a) if pathology services of a kind referred to in item 65090 or 65093 are rendered for a patient during a period when the patient is in hospital, the item applies only to the first pathology service of that kind rendered for the patient during the period; and

(b) if:

(i) tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out in relation to a patient episode; and

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

(iii) in response to a request made within 14 days of the patient episode, further tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out on the stored material;

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

5. (2) Benefits for items 65102 and 65108 are payable only if a minimum of 6 units are issued for the patient's care in any 1 day.

5.(3) For items 65099 and 65102:

compatibility tests by crossmatch means that, in addition to all the tests described in paragraphs (a) and (b) of the item, donor red cells from each unit must have been tested directly against the serum of the patient by 1 or more accepted crossmatching techniques.

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

6. (1) In this rule:

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

(a) tests of the kind described in item 66695; or

(b) tests of the kind described in item 66722; or

(c) tests of the kind described in item 66800; or

(d) tests of the kind described in item 66812; or

(e) tests of the kind described in item 69384.

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

(a) an approved pathology practitioner (***practitioner A)*** in an approved pathology authority:

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

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

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

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

(b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item 66710, 66734, 66806, 66815 or 69399.

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

(a) item 66695, 66698, 66701, 66704, 66707, 66722, 66725, 66728, 66731, 66800, 66803, 66812, 69384, 69387, 69390, 69393 or 69396 (as the case requires) applies in respect of the test or tests rendered by practitioner A; and

(b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) - subject to subrule (4), the amount specified in item 66713, 66737, 66809, 66818, or 69402 (as the case requires) is payable for each test that the service comprises.

6. (4) For paragraph (3) (b), the maximum number of tests to which item 66713, 66737, 66809, 66818, or 69402 applies is:

(a) for item 66818:

2 - **X**; or

(b) for item 66809:

3 – X; or

(c) for item 66713, 66737 or 69402:

6 - **X**;

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

6. (5) Items in Group P10 (Patient episode initiation) do not apply to the second-mentioned approved pathology practitioner in subrule (2).

Items not to be split

7. Except as stated in rule 6, the amount specified in an item is payable only to one approved pathology practitioner in respect of a single patient episode.

Creatinine ratios – Group P2 (chemical)

8. A pathology service mentioned in an item (except item 66500) in Group P2 (chemical) that:
(a) involves the measurement of a substance in urine; and
(b) requires calculation of a substance/creatinine ratio;
is taken to include the measurement of creatinine necessary for the calculation.

Thyroid function testing

9. (1) For item 66719:

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

9. (2) Except where paragraph (a) of item 66719 is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

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

(a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item 66719; or
(b) that the medical practitioner who requested the tests suspects the patient has pituitary dysfunction; or
(c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

Meaning of "serial examinations or cultures"

10. For an item in Group P3 (Microbiology):

(a) ***serial examinations or cultures*** means a series of examinations or cultures requested on 1 occasion whether or not:
  (i) the materials are received on different days by the approved pathology practitioner; or
  (ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and
(b) if:
  (i) tests are carried out in relation to a patient episode; and
  (ii) specimen material from the patient episode is stored; and
  (iii) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;
the later tests and the earlier tests are taken to be part of one patient episode.

Investigation for hepatitis serology

11. (1) A medicare benefit is not payable in respect of more than one of items 69475, 69478 and 69481 in a patient episode.

11. (2) Item 69478 applies to a service in relation to which:
(a) a practitioner requests 2 tests for immune status or viral carriage; or
(b) the clinical notes indicate that the service is required for:
  i. pre-operative assessment; or
  ii. post-exposure to blood or other bodily fluids assessment; or
  iii. assessment before blood or tissue donation.

11. (3) Item 69481 applies to a service in relation to a patient who displays one or more of the characteristics of acute or chronic hepatitis.

Tests in Group P4 (Immunology) relating to antibodies

12. For items in Group P4 (Immunology), in items 71119, 71121, 71123 and 71125, if:

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

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

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

13. (1) For items in Group P5 (Tissue pathology):

(a) ***biopsy material*** means all tissue (other than a bone marrow biopsy) received by the Approved Pathology Practitioner:
(i) from a medical procedure or group of medical procedures performed on a patient at the same time; or
(ii) after being expelled spontaneously from a patient.
(b) ***cytology*** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant but, in accordance with customary laboratory practice, does not include examination of a blood film and a bone marrow aspirate; and
(c) ***separately identified specimen*** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.

13. (2) For Groups P5 and P6 of the pathology services table, services in Group P6 include any services described in Group P5 on the material submitted for a test in Group P6.

13. (3) For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

13.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 are performed in a single patient episode, a medicare benefit is payable only for the item performed that has the highest schedule fee.

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

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

13.(7) If more than 1 of the services mentioned in items 72846, 72847 and 72848 or 73059, 73060 and 73061 are performed in a single patient episode, a medicare benefit is payable only for the item performed that has the highest scheduled fee.

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

14. (1) For this rule and items in Groups P10 (Patient episode initiation) and P11 (Specimen referred):

approved collection centre has the same meaning as in Part IIA of the Act.

institution means a place at which residential accommodation or day care is, or both residential accommodation and day care are, made available to:

(a) disadvantaged children; or
(b) juvenile offenders; or
(c) aged persons; or
(d) chronically ill psychiatric patients; or
(e) homeless persons; or
(f) unemployed persons; or
(g) persons suffering from alcoholism; or

(h) persons addicted to drugs; or
(i) physically or mentally handicapped persons;
but does not include:
(j) a hospital; or
(k) a residential aged care home; or
(l) accommodation for aged persons that is attached to a residential aged care home or situated within a residential aged care home.

prescribed laboratory means a laboratory operated by:
(a) the Australian Government; or
(b) an authority of the Commonwealth; or
(c) a State or internal Territory; or
(d) an authority of a State or internal Territory; or
(e) an Australian tertiary education institution.

s*pecimen collection centre* has the same meaning as in Part IIA of the Act.

treating practitioner has the same meaning as in paragraph 16A(1)(a) of the Act.

14. (2) If a service described in an item in Group P10 is rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:

(a) the service is rendered upon a request made in the course of an out-patient service at a recognised hospital; or
(b) the service is rendered upon a request made for a patient who is a private patient in a recognised hospital when the request is made; or
(c) the pathology equipment of a recognised hospital, or a prescribed laboratory, is used rendering the service; or
(d) a member of the staff of a recognised hospital, or a prescribed laboratory, participates in the service in the course of the member's employment with the hospital or laboratory.

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

14. (4) An item in Group P10 or P11 does not apply to a pathology service unless at least 1 item in Groups P1 to P8 also applies to the service.

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

14. (6) An item in Group P11 applies only to the approved pathology practitioner or approved pathology authority to whom the specimen mentioned in the item was referred.

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

(a) services referred to in 1 or more items in Group P5 and 1 or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; or
(b) services referred to in 1 or more items in Group P6 and 1 or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in the laboratory of another approved pathology authority;

the fee specified in the applicable item in Group P10 is payable to both approved pathology practitioners.

14. (8) If more than one specimen is collected from a person on the same day for the provision of pathology services:

(a) in accordance with more than 1 request; and
(b) in or by a single approved pathology authority;

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

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

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

15. If item 73921 applies to a patient episode, none of the items in Group P10 applies to any pathology service rendered by the approved pathology authority or approved pathology practitioner who claimed item 73921 in respect of the patient episode.

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

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

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

16. (2) An approved pathology authority is ***related to*** another approved pathology authority for subrule (1) if:

(a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or
(b) either of the approved pathology authorities is employed (including employed under contract) by the other; or
(c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations Act; or
(d) the approved pathology authorities are partners (whether or not either or both of the approved pathology authorities are individuals and whether or not other persons are in partnership with either or both of the approved pathology authorities; or
(e) both approved pathology authorities are operated by the Commonwealth or an authority of the Commonwealth; or
(f) both approved pathology authorities are operated by the same State or internal Territory or an authority of the same State or internal Territory.

16. (3) An item in Group P11 does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): 65060, 65070, 65120, 66500, 66503, 66506, 66509, 66512, 66515, 66536, 66596, 69300, 69303, 69333 or 73527.

Abbreviations

17. (1) The abbreviations in Part 4 of this table may be used to identify particular pathology services or groups of pathology services.

17. (2) The names of services or drugs not listed in Part 4 of this table must be written in full.

Certain pathology services to be treated as 1 service

18. (1) In this rule:

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

set of pathology services means a group of pathology services:
(a) that consists of services that are described in at least 4 different items; and
(b) all of which are requested in a single patient episode; and
(c) each of which relates to a patient who is not an admitted patient of a hospital; and
(d) none of which is referred to:
  (i) in item 66713, 66737, 66809, 66818, 69402, 69484, 73053 or 73055; or
  (ii) in an item in Group P10 (Patient episode initiation), Group P11 (Specimen referred) or Group P12 (Management of bulk-billed services).

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

18. (3) If the fee specified in 1 item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service described in the first-mentioned item is to be treated as 1 pathology service; and

(b) either:
(i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as 1 pathology service; or
(ii) if 2 or more items that describe any of those services specify the second-highest fee - the pathology service described in the item that specifies the second-highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (4) If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
(b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as 1 pathology service; and
(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (5) If pathology services are to be treated as one pathology service under paragraph (3) (c) or (4) (c), the fee for the one pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the 1 pathology service.

Hepatitis C viral RNA testing

19. For item 69444:

Hepatitis C sero-positive, for a patient, means 2 different assays of Hepatitis C antibodies are positive.

serological status is uncertain**,** for a patient, means any result where 2 different assays of Hepatitis C antibodies are inconclusive.

Haemochromatosis testing

20. For item 66794:

elevated serum ferritin for a patient, means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level.

Serum B12 and red cell folate testing

21. (1) For items 66599 and 66602, a medicare benefit is not payable for more than 3 episodes of services described in item 66599 or 66602, or any combination of those items, in a 12 month period.

21. (2) A medicare benefit is not payable for a service described in item 66599 if the service was provided as part of the same patient episode as a service described in item 66602.

Nutritional and toxicity metals testing

22. (1) For this rule:
nutritional metals testing group means items 66669 and 66670.
metal toxicity testing group means items 66672 and 66673.

22. (2) An item in the nutritional metals testing group or the metal toxicity testing group does not apply in relation to a service performed if medicare benefits are paid or payable for tests that are performed for the same patient in 3 patient episodes requested within 6 months before the request for that service, under any of:
(a) that item; or
(b) the other item in the same group; or
(c) an item in the other group.

Antineutrophil Cytoplasmic Antibody

23. A request for Antineutrophil Cytoplasmic Antibody immunofluorescence test (ANCA) shall be deemed to include requests for antineutrophil proteinase 3 antibody test (PR-3 ANCA) and antimyeloperoxidase antibody test (MPO

ANCA) where the immunofluorescence test for ANCA is abnormal, or has been abnormal, or those specific antibodies have been previously detected.

Satisfying Requirements Described in Items

24. Unless stated elsewhere in these rules, where an item contains a requirement, this requirement is satisfied if:

(a) The requirement/s as stipulated in the item descriptor are contained in the request form; or
(b) The requirement/s as stipulated in the item descriptor were supplied previously in writing to the APA and this documentation is retained by the APA; or
(c) The results of other laboratory tests performed in the same episode meet the requirement/s as stipulated in the item descriptor; or
(d) The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are supplied on the request form; or

The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are contained in the APA's records.

Limitation on certain items

25. (a) For any particular patient, items 66539, 69442, 71075, 71127, 71135 or 71137 are applicable not more than twice in a 12 month period.
(b) For any particular patient, item 66626 is applicable not more than 36 times in a 12 month period.
(c) For any particular patient, items 66655, 66659, 69443 or 69444 are applicable not more than once in a 12 month period.
(d) For any particular patient, item 66750 is applicable not more than once in a pregnancy.
(e) For any particular patient, item 69336 is applicable not more than once in each period of 7 days.
(f) For any particular patient, items 69445, 71079, or 73523 are applicable not more than 4 times in a 12 month period.
(g) For any particular patient, item 71077 is applicable not more than 6 times in a 12 month period.

Antigen Detection – Group P3 (Microbiology)

26. If the service listed in 69364 or 69365 is a pathologist determinable service the specialist pathologist is required to record the reasons for determining the need for this service.

GROUP P1 - HAEMATOLOGY

65060	Haemoglobin, erythrocyte sedimentation rate, blood viscosity - 1 or more tests **Fee:** $8.95	**Benefit:** 75% $6.00	85% $6.80
65066	Examination of: (a) a blood film by special stains to demonstrate Heinz bodies, parasites or iron;or (b) a blood film by enzyme cytochemistry for neutrophil alkaline phosphatase, alpha-naphthyl acetate esterase or chloroacetate esterase;or (c) a blood film using any other special staining methods including periodic acid Schiff and Sudan Black;or (d) a urinary sediment for haemosiderin including a service described in item 65072 **Fee:** $10.55	**Benefit:** 75% $7.95	85% $9.00
65070	Erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count - not being a service where haemoglobin only is requested - one or more instrument generated set of results from a single sample;and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072 **Fee:** $17.20	**Benefit:** 75% $12.90	85% $14.65
65072	Examination for reticulocytes including a reticulocyte count by any method - 1 or more tests **Fee:** $10.30	**Benefit:** 75% $7.75	85% $8.80
65075	Haemolysis or metabolic enzymes - assessment by: (a) erythrocyte autohaemolysis test;or (b) erythrocyte osmotic fragility test;or (c) sugar water test;or (d) G-6-P D (qualitative or quantitative) test;or (e) pyruvate kinase (qualitative or quantitative) test;or (f) acid haemolysis test;or (g) quantitation of muramidase in serum or urine;or (h) Donath Landsteiner antibody test;or (i) other erythrocyte metabolic enzyme tests 1 or more tests **Fee:** $12.90	**Benefit:** 75% $9.70	85% $11.00
65078	Tests for the diagnosis of thalassaemia when indicated on the basis of an abnormal full blood examination or by the clinical need for family studies, consisting of haemoglobin electrophoresis or chromatography and at least 2 of: (a) examination for HbH;or (b) quantitation of HbA2;or (c) quantitation of HbF; including (if performed) any service described in item 65060 or 65070 **Fee:** $11.75	**Benefit:** 75% $8.85	85% $10.00
65081	Tests for the investigation of haemoglobinopathy (including S, C, D, E), other than thalassaemia, when indicated on the basis of an abnormal full blood examination or by the clinical need for family studies, consisting of haemoglobin electrophoresis or chromatography and at least 1 of: (a) heat denaturation test;or (b) isopropanol precipitation test;or (c) tests for the presence of haemoglobin S;or (d) quantitation of any haemoglobin fraction (including S, C, D, E); including (if performed) any service described in item 65060, 65070 or 65078 **Fee:** $18.25	**Benefit:** 75% $13.70	85% $15.55
65084	Bone marrow trephine biopsy - histopathological examination of sections of bone marrow and examination of aspirated material (including clot sections where necessary), including (if performed): (a) special stains or immunohistochemical techniques (if any);and (b) any test described in item 65060, 65066 or 65070 **Fee:** $68.75	**Benefit:** 75% $26.60	85% $43.45
65087	Bone marrow - examination of aspirated material (including clot sections where necessary), including (if performed): (a) special stains or immunohistochemical techniques (if any);and (b) any test described in item 65060, 65066 or 65070 **Fee:** $44.55	**Benefit:** 75% $33.45	85% $31.90

65090	Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen) **Fee:** $1.25	**Benefit:** 75% $1.45	85% $1.60
65093	Blood grouping - Rh phenotypes, Kell system, Duffy system, M and N factors or any other blood group system - 1 or more systems, including item 65090 (if performed) **Fee:** $2.35	**Benefit:** 75% $2.80	85% $3.00
65096	Blood grouping (including back-grouping if performed), and examination of serum for Rh and other blood group antibodies, including: (a) identification and quantitation of any antibodies detected;and (b) (if performed) any test described in item 65060 or 65070 **Fee:** $1.65	**Benefit:** 75% $1.25	85% $5.45
65099	Compatibility tests by crossmatch - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor;and (b) examination for antibodies, and if necessary identification of any antibodies detected;and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5) **Fee:** $13.40	**Benefit:** 75% $5.05	85% $6.40
65102	Compatibility tests by crossmatch - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor;and (b) examination for antibodies, and if necessary identification of any antibodies detected;and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5) **Fee:** $70.10	**Benefit:** 75% $27.60	85% $44.60
65105	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor;and (b) examination for antibodies and, if necessary, identification of any antibodies detected;and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5) **Fee:** $13.40	**Benefit:** 75% $5.05	85% $6.40
65108	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor;and (b) examination for antibodies and, if necessary, identification of any antibodies detected;and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5) **Fee:** $70.10	**Benefit:** 75% $27.60	85% $44.60
65111	Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected) **Fee:** $23.60	**Benefit:** 75% $17.70	85% $20.10
65114	1 or more of the following tests: (a) direct Coombs (antiglobulin) test; (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies **Fee:** $9.25	**Benefit:** 75% $6.95	85% $7.90
65117	1 or more of the following tests: (a) Spectroscopic examination of blood for chemically altered haemoglobins; (b) detection of methaemalbumin (Schumm's test) **Fee:** $10.60	**Benefit:** 75% $5.45	85% $7.55
65120	Prothrombin time (including INR where appropriate), activated partial thromboplastin time, thrombin time (including test for the presence of heparin), test for factor XIII deficiency (qualitative), Echis test, Stypven test, reptilase time, fibrinogen, or 1 of fibrinogen degradation products, fibrin monomer or D-dimer - 1 test **Fee:** $4.05	**Benefit:** 75% $0.55	85% $1.95
65123	2 tests described in item 65120 **Fee:** $10.60	**Benefit:** 75% $5.45	85% $7.55
65126	3 tests described in item 65120 **Fee:** $18.35	**Benefit:** 75% $1.30	85% $4.10

65129	4 or more tests described in item 65120 **Fee:** $6.10	**Benefit:** 75% $7.10	85% $0.70
65132	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency, lupus anticoagulant, activated protein C resistance - where the request for the test(s) specifically identifies that the patient has a history of venous thromboembolism - quantitation by 1 or more techniques - 1 test **Fee:** $5.75	**Benefit:** 75% $9.35	85% $1.90
65133	2 tests described in item 65132 **Fee:** $9.50	**Benefit:** 75% $7.15	85% $2.10
65134	3 tests described in item 65132 **Fee:** $3.20	**Benefit:** 75% $4.90	85% $2.25
65135	4 tests described in item 65132 **Fee:** $6.90	**Benefit:** 75% $2.70	85% $2.40
65136	5 tests described in item 65132 **Fee:** $20.65	**Benefit:** 75% $0.50	85% $02.60
65137	Test for the presence of lupus anticoagulant not being a service associated with any service to which items 65132, 65133, 65134, 65135 and 65136 apply **Fee:** $5.75	**Benefit:** 75% $9.35	85% $1.90
65142	Confirmation or clarification of an abnormal or indeterminate result from a test described in item 65132, by testing a specimen collected on a different day - 1 or more tests **Fee:** $5.75	**Benefit:** 75% $9.35	85% $1.90
65144	Platelet aggregation in response to ADP, collagen, 5HT, ristocetin or other substances;or heparin, low molecular weight hepari ns, heparinoid or other drugs - 1 or more tests **Fee:** $7.55	**Benefit:** 75% $3.20	85% $8.95
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test **Fee:** $8.55	**Benefit:** 75% $8.95	85% $2.80
65150	Quantitation of von Willebrand factor antigen, von Willebrand factor activity (ristocetin cofactor assay), von Willebrand factor collagen binding activity, factor II, factor V, factor VII, factor VIII, factor IX, factor X, factor XI, factor XII, factor XIII, Fletcher factor, Fitzgerald factor, circulating coagulation factor inhibitors other than by Bethesda assay - 1 test **Fee:** $2.15	**Benefit:** 75% $4.15	85% $1.35
65153	2 tests described in item 65150 **Fee:** $44.35	**Benefit:** 75% $08.30	85% $22.70
65156	3 or more tests described in item 65150 **Fee:** $16.50	**Benefit:** 75% $62.40	85% $84.05
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test **Fee:** $2.15	**Benefit:** 75% $4.15	85% $1.35
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test) **Fee:** $0.55	**Benefit:** 75% $.95	85% $.00
65165	Detection and quantitation of fetal red blood cells in the maternal circulation by detection of red cell antigens using flow cytometric methods including (if performed) any test described in item 65070 or 65162 **Fee:** $5.05	**Benefit:** 75% $6.30	85% $9.80
65168	Characterisation of the genotype of a patient for Factor V Leiden gene mutation, or detection of other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism - 1 or more tests **Fee:** $7.10	**Benefit:** 75% $7.85	85% $1.55
65171	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above - 1 or more tests **Fee:** $5.75	**Benefit:** 75% $9.35	85% $1.90

65174	Characterisation of the genotype of a person who is a first degree relative of a person who has been proven to have 1 or more abnormal genotypes under item 65168 - 1 or more tests **Fee:** $37.10	**Benefit:** 75% $27.85	85% $31.55
65200	Characterisation of gene rearrangement by nucleic acid amplification in the diagnosis and monitoring of patients with laboratory evidence of: (a) acute myeloid leukaemia;or (b) acute promyelocytic leukaemia;or (c) acute lymphoid leukaemia;or (d) chronic myeloid leukaemia; each test to a maximum of 4 tests in a 12 month period **Fee:** $335.00	**Benefit:** 75% $176.25	85% $199.75
	GROUP P2 - CHEMICAL		
66500	Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter) of: acetoacetate, ac id phosphatase, alanine aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, beta-hydroxybutyrate, bicarbonate, bilirubin (total), bilirubin (any fractions), C-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, pyruvate, sodium, total protein, total cholesterol, triglycerides, urate or urea - 1 test **Fee:** $9.75	**Benefit:** 75% $7.35	85% $8.30
66503	2 tests described in item 66500 **Fee:** $11.75	**Benefit:** 75% $8.85	85% $10.00
66506	3 tests described in item 66500 **Fee:** $13.75	**Benefit:** 75% $10.35	85% $11.70
66509	4 tests described in item 66500 **Fee:** $15.75	**Benefit:** 75% $11.85	85% $13.40
66512	5 tests described in item 66500 **Fee:** $17.80	**Benefit:** 75% $13.35	85% $15.15
66515	6 or more tests described in item 66500 **Fee:** $19.80	**Benefit:** 75% $14.85	85% $16.85
66518	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 1 specimen in a 24 hour period **Fee:** $20.40	**Benefit:** 75% $15.30	85% $17.35
66519	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 2 or more specimens in a 24 hour period **Fee:** $40.85	**Benefit:** 75% $30.65	85% $34.75
66536	Quantitation of HDL cholesterol **Fee:** $11.25	**Benefit:** 75% $8.45	85% $9.60
66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is 6.5 mmol/L and triglyceride 4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaemia - 1 of this item to a maximum of 2 in a 12 month period **Fee:** $41.15	**Benefit:** 75% $43.40	85% $46.50
66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose;and (b) at least 2 measurements of blood glucose;and (c) (if performed) any test described in item 66695 **Fee:** $59.30	**Benefit:** 75% $44.50	85% $46.45

66545	Oral glucose challenge test in pregnancy for the detection of gestational diabetes that includes: (a) administration of glucose;and (b) 1 or 2 measurements of blood glucose;and (c) (if performed) any test in item 66695 **Fee:** $6.10	**Benefit:** 75% $2.10	85% $3.70
66548	Oral glucose tolerance test in pregnancy for the diagnosis of gestational diabetes that includes: (a) administration of glucose;and (b) at least 3 measurements of blood glucose;and (c) any test in item 66695 (if performed) **Fee:** $20.30	**Benefit:** 75% $5.25	85% $7.30
66551	Quantitation of glycosylated haemoglobin performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period **Fee:** $7.10	**Benefit:** 75% $2.85	85% $4.55
66554	Quantitation of glycosylated haemoglobin performed in the management of pre-existing diabetes where the patient is pregnant - each test to a maximum of 6 tests in a 12 month period which includes the whole pregnancy, including a service in item 66551 (if performed) **Fee:** $7.10	**Benefit:** 75% $2.85	85% $4.55
66557	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period **Fee:** $9.85	**Benefit:** 75% $3.40	85% $8.40
66560	Microalbumin - quantitation in urine **Fee:** $20.50	**Benefit:** 75% $5.40	85% $7.45
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests **Fee:** $15.10	**Benefit:** 75% $8.85	85% $11.35
66566	Quantitation of: (a) blood gases (including pO_2, oxygen saturation and pCO_2) ;and (b) bicarbonate and pH; including any other measurement (eg. haemoglobin, potassium or ionised calcium) or calculation performed on the same specimen - 1 or more tests on 1 specimen **Fee:** $34.30	**Benefit:** 75% $25.75	85% $29.20
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day **Fee:** $43.35	**Benefit:** 75% $32.55	85% $36.85
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day **Fee:** $52.45	**Benefit:** 75% $39.35	85% $44.60
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day **Fee:** $61.50	**Benefit:** 75% $46.15	85% $52.30
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day **Fee:** $70.55	**Benefit:** 75% $52.95	85% $60.00
66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day **Fee:** $79.65	**Benefit:** 75% $59.75	85% $67.75
66584	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test **Fee:** $9.85	**Benefit:** 75% $7.40	85% $8.40
66587	Urine acidification test for the diagnosis of renal tubular acidosis including the administration of an acid load, and pH measurements on 4 or more urine specimens and at least 1 blood specimen **Fee:** $48.35	**Benefit:** 75% $36.30	85% $41.10
66590	Calculus, analysis of 1 or more **Fee:** $31.15	**Benefit:** 75% $23.40	85% $26.50

66593	Ferritin - quantitation, except if requested as part of iron studies **Fee:** $8.35	**Benefit:** 75% $3.80	85% $5.60
66596	Iron studies, consisting of quantitation of: (a) serum iron;and (b) transferrin or iron binding capacity;and (c) ferritin **Fee:** $3.10	**Benefit:** 75% $4.85	85% $8.15
66599	Serum B12 or red cell folate and, if required, serum folate (Item is subject to rule 21) **Fee:** $4.05	**Benefit:** 75% $8.05	85% $10.45
66602	Serum B12 and red cell folate and, if required, serum folate (Item is subject to rule 21) **Fee:** $3.75	**Benefit:** 75% $2.85	85% $7.20
66605	Vitamins - quantitation of vitamins A, B1, B2, B3, B6, C and E in blood, urine or other body fluid - 1 or more tests within a 6 month period **Fee:** $1.15	**Benefit:** 75% $3.40	85% $6.50
66608	Vitamin D or D fractions - 1 or more tests **Fee:** $3.00	**Benefit:** 75% $2.25	85% $6.55
66623	All qualitative and quantitative tests on blood, urine or other body fluid for: (a) a drug or drugs of abuse (including illegal drugs and legally available drugs taken other than in appropriate dosage);or (b) ingested or absorbed toxic chemicals; including a service described in item 66800, 66803, 66806, 66812 or 66815 (if performed), but excluding: (c) the surveillance of sports people and athletes for performance improving substances;and (d) the monitoring of patients participating in a drug abuse treatment program **Fee:** $2.25	**Benefit:** 75% $1.70	85% $5.95
66626	Detection or quantitation or both (not including the detection of nicotine and metabolites in smoking withdrawal programs) of a drug, or drugs, of abuse or a therapeutic drug, on a sample collected from a patient participating in a drug abuse treatment program;but excluding the surveillance of sports people and athletes for performance improving substances;including all tests on blood, urine or other body fluid - 1 of this item to a maximum of 36 in a 12 month period **Fee:** $4.55	**Benefit:** 75% $8.45	85% $10.90
66629	Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests **Fee:** $0.50	**Benefit:** 75% $5.40	85% $7.45
66632	Caeruloplasmin, haptoglobins, or prealbumin - quantitation in serum, urine or other body fluids - 1 or more tests **Fee:** $0.50	**Benefit:** 75% $5.40	85% $7.45
66635	Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests **Fee:** $0.50	**Benefit:** 75% $5.40	85% $7.45
66638	Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum - 1 or more tests **Fee:** $9.70	**Benefit:** 75% $2.30	85% $5.25
66641	Electrophoresis of serum or other body fluid to demonstrate: (a) the isoenzymes of lactate dehydrogenase;or (b) the isoenzymes of alkaline phosphatase; including the preliminary quantitation of total relevant enzyme activity - 1 or more tests **Fee:** $9.70	**Benefit:** 75% $2.30	85% $5.25
66644	C-1 esterase inhibitor - quantitation **Fee:** $0.50	**Benefit:** 75% $5.40	85% $7.45
66647	C-1 esterase inhibitor - functional assay **Fee:** $5.90	**Benefit:** 75% $4.45	85% $9.05

	Alpha-fetoprotein, CA-15.3 antigen (CA15.3), CA-125 antigen (CA125), CA-19.9 antigen (CA19.9), cancer associated serum antigen (CASA), carcinoembryonic antigen (CEA), human chorionic gonadotrophin (HCG), mammary serum antigen (MSA), thyroglobulin in serum or other body fluid, in the monitoring of malignancy or in the detection or monitoring of hepatic tumours, gestational trophoblastic disease or germ cell tumour - quantitation - 1 test			
66650	**Fee:** $14.75	**Benefit:** 75% $8.60	85% $11.05	
	2 or more tests described in item 66650			
66653	**Fee:** $25.35	**Benefit:** 75% $14.05	85% $18.55	
	Prostate specific antigen - quantitation - 1 of this item in a 12 month period			
66655	**Fee:** $10.50	**Benefit:** 75% $5.40	85% $7.45	
	Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655)			
66656	**Fee:** $10.50	**Benefit:** 75% $5.40	85% $7.45	
	Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the followup of a PSA result which lies in the equivocal range of the particular method of assay used to determine the level - 1 of this item in a 12 month period			
66659	**Fee:** $17.80	**Benefit:** 75% $8.35	85% $12.15	
	Quantitation of hormone receptors on proven primary breast or ovarian carcinoma or a metastasis from a breast or ovarian carcinoma or a subsequent lesion in the breast - 1 or more tests			
66662	**Fee:** $21.35	**Benefit:** 75% $11.05	85% $19.15	
	Lead quantitation in blood or urine (other than for occupational health screening purposes) to a maximum of 3 tests in a 6 month period - each test			
66665	**Fee:** $11.15	**Benefit:** 75% $3.40	85% $6.50	
	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test			
66667	**Fee:** $11.15	**Benefit:** 75% $3.40	85% $6.50	
	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22)			
66669	**Fee:** $11.15	**Benefit:** 75% $3.40	85% $6.50	
	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 2 or more tests. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22)			
66670	**Fee:** $23.35	**Benefit:** 75% $10.05	85% $15.35	
	Quantitation of serum aluminium in a patient in a renal dialysis program - each test			
66671	**Fee:** $17.55	**Benefit:** 75% $8.20	85% $11.95	
	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22)			
66672	**Fee:** $11.15	**Benefit:** 75% $3.40	85% $6.50	
	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 2 or more tests. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22)			
66673	**Fee:** $23.35	**Benefit:** 75% $10.05	85% $15.35	
	Quantitation of: (a) faecal fat;or (b) breath hydrogen in response to loading with disaccharides; 1 or more tests within a 28 day period			
66674	**Fee:** $10.65	**Benefit:** 75% $0.50	85% $4.60	
	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old			
66677	**Fee:** $1.35	**Benefit:** 75% $.55	85% $.65	

66680	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests **Fee:** $35.75	**Benefit:** 75% $26.85	85% $30.40
66683	Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests **Fee:** $35.75	**Benefit:** 75% $26.85	85% $30.40
66686	Performance of 1 or more of the following procedures: (a) growth hormone suppression by glucose loading; (b) growth hormone stimulation by exercise; (c) dexamethasone suppression test; (d) sweat collection by iontophoresis for chloride analysis; (e) pharmacological stimulation of growth hormone **Fee:** $51.55	**Benefit:** 75% $38.70	85% $43.85
66695	Quantitation in blood or urine of hormones and hormone binding proteins - ACTH, aldosterone, androstenedione, C-peptide, calcitonin, cortisol, cyclic AMP, DHEAS, 11-deoxycortisol, dihydrotestosterone, FSH, gastrin, glucagon, growth hormone, hydroxyprogesterone, insulin, LH, oestradiol, oestrone, progesterone, prolactin, PTH, renin, sex hormone binding globulin, somatomedin C(IGF-1), free or total testosterone, urine steroid fraction or fractions, vasoactive intestinal peptide, vasopressin (antidiuretic hormone) - 1 test **Fee:** $40.70	**Benefit:** 75% $33.05	85% $36.10
66698	2 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $63.80	**Benefit:** 75% $52.85	85% $57.25
66701	3 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $87.20	**Benefit:** 75% $72.90	85% $78.65
66704	4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $90.60	**Benefit:** 75% $72.95	85% $80.05
66707	5 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $94.05	**Benefit:** 75% $63.05	85% $71.45
66710	6 or more tests described in item 66695 (Item is subject to rule 6) **Fee:** $97.45	**Benefit:** 75% $73.10	85% $82.85
H 66711	Quantitation in saliva of cortisol in: (a) the investigation of Cushing's syndrome;or (b) the management of children with congenital adrenal hyperplasia **Fee:** $40.70	**Benefit:** 75% $33.05	85% $36.10
H 66712	Two tests described in item 66714 **Fee:** $63.80	**Benefit:** 75% $52.85	85% $57.25

	Tests described in item 66695, if rendered under a request referred to in subparagraph (2)(a)(iii) of rule 6 - each test to a maximum of 5 tests (Item is subject to rule 6)		
66713	**Fee:** $3.40	**Benefit:** 75% $0.05	85% $1.40
66716	TSH quantitation **Fee:** $5.45	**Benefit:** 75% $9.10	85% $1.65
66719	Thyroid function tests (comprising the service described in item 66716 and 1 or more of the following tests - estimation of free thyroxine index, free thyroxine, free T3, total T3, thyroxine binding globulin) for a patient, if at least 1 of the following conditions is satisfied: (a) the patient has an abnormal level of TSH; (b) the tests are performed: (i) for the purpose of monitoring thyroid disease in the patient;or (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient;or (iii) to investigate dementia or psychiatric illness of the patient;or (iv) to investigate amenorrhoea or infertility of the patient; (c) the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction; (d) the patient is on drugs that interfere with thyroid hormone metabolism or function (Item is subject to rule 9) **Fee:** $5.45	**Benefit:** 75% $6.60	85% $0.15
66722	TSH quantitation described in item 66716 and 1 test described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $8.55	**Benefit:** 75% $8.95	85% $2.80
66725	TSH quantitation described in item 66716 and 2 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $1.95	**Benefit:** 75% $9.00	85% $4.20
66728	TSH quantitation described in item 66716 and 3 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $5.35	**Benefit:** 75% $9.05	85% $5.55
66731	TSH quantitation described in item 66716 and 4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $8.75	**Benefit:** 75% $9.10	85% $6.95
66734	TSH quantitation described in item 66716 and 5 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 6 or more tests specified on the request form) (Item is subject to rule 6) **Fee:** $2.15	**Benefit:** 75% $9.15	85% $8.35
66737	Tests described in items 66716 and 66695, if rendered under a request mentioned in subparagraph (2)(a)(iii) of rule 6 - each test to a maximum of 5 tests (Item is subject to rule 6) **Fee:** $3.40	**Benefit:** 75% $0.05	85% $1.40

66743	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751 **Fee:** $30.50	**Benefit:** 75% = $25.40	85% = $27.45
66749	Amniotic fluid, spectrophotometric examination of, and quantitation of: (a) lecithin/sphingomyelin ratio;or (b) palmitic acid, phosphatidylglycerol or lamellar body phospholipid;or (c) bilirubin, including correction for haemoglobin 1 or more tests **Fee:** $33.50	**Benefit:** 75% = $25.15	85% = $28.50
66750	Quantitation, in pregnancy, of any two of the following - total human chorionic gonadotrophin (total HCG), free alpha human chorionic gonadotrophin (free alpha HCG), free beta human chorionic gonadotrophin (free beta HCG), pregnancy associated plasma protein A (PAPP-A), unconjugated oestriol (uE_3), alpha-fetoprotein (AFP) - to detect foetal abnormality, including a service described in 1 or more of items 73527 and 73529 (if performed) - 1 of this item in a pregnancy **Fee:** $40.45	**Benefit:** 75% = $30.35	85% = $34.40
66751	Quantitation, in pregnancy, of any three or more tests described in 66750 **Fee:** $56.20	**Benefit:** 75% = $42.15	85% = $47.80
66752	Quantitation of citrate, oxalate, total free fatty acids or amino acids including cysteine, homocysteine, cystine and hydroxyproline (except if performed as part of item 66773 or 66776) - 1 test **Fee:** $35.10	**Benefit:** 75% = $26.35	85% = $29.85
66755	2 or more tests described in item 66752 **Fee:** $39.50	**Benefit:** 75% = $29.65	85% = $33.60
66758	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests **Fee:** $35.10	**Benefit:** 75% = $26.35	85% = $29.85
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick) **Fee:** $13.40	**Benefit:** 75% = $10.05	85% = $11.40
66764	Examination for faecal occult blood (including tests for haemoglobin and its derivatives in the faeces) by: (a) an immunological method;and (b) a chemical method (except reagent strip or dip stick); with a maximum of 3 examinations on specimens collected on separate days in a 28 day period - 1 examination by both methods *(See para PP. of explanatory notes to this Category)* **Fee:** $9.05	**Benefit:** 75% = $6.80	85% = $7.70
66767	2 examinations by both methods described in item 66764 performed on separately collected and identified specimens **Fee:** $18.15	**Benefit:** 75% = $13.65	85% = $15.45
66770	3 examinations by both methods described in item 66764 performed on separately collected and identified specimens **Fee:** $27.20	**Benefit:** 75% = $20.40	85% = $23.15
66773	Quantitation of products of collagen breakdown for the monitoring of patients with proven low bone mineral density, and if performed, a service described in item 66752 - 1 or more tests *(Low bone densitometry is defined in the explanatory notes to Category 2 - Diagnostic Procedures and Investigations of the Medicare Benefits Schedule)* ***Fee:** $25.10*	***Benefit:** 75% = $18.85*	*85% = $21.35*
66776	Quantitation of products of collagen breakdown for the monitoring of patients with metabolic bone disease or Paget's disease of bone, and if performed, a service described in item 66752 - 1 or more tests **Fee:** $35.10	**Benefit:** 75% = $26.35	85% = $29.85
66779	Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (5HIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA) or serotonin quantitation - 1 or more tests **Fee:** $40.65	**Benefit:** 75% = $30.50	85% = $34.60
66782	Porphyrins or porphyrins precursors - detection in plasma, red cells, urine or faeces - 1 or more tests **Fee:** $13.40	**Benefit:** 75% = $10.05	85% = $11.40

66785	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 1 test **Fee:** $40.65	**Benefit:** 75% $30.50	85% $34.60
66788	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests **Fee:** $67.00	**Benefit:** 75% $50.25	85% $56.95
66791	Porphyrin biosynthetic enzymes - measurement of activity in blood cells or other tissues - 1 or more tests **Fee:** $75.75	**Benefit:** 75% $56.85	85% $64.40
66794	Detection of the C282Y genetic mutation of the HFE gene and, if performed, detection of other mutations for haemochromatosis where: (a) the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens;or (b) the patient has a first degree relative with haemochromatosis;or (c) the patient has a first degree relative with homozygosity for the C282Y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis (Item is subject to rule 20) **Fee:** $97.10	**Benefit:** 75% $87.85	85% $91.55
66800	Quantitation in blood, urine or other body fluid by any method (except reagent tablet or reagent strip) of any of the following being used therapeutically by the patient from whom the specimen was taken:amikacin, carbamazepine, digoxin, disopyramide, ethanol, ethosuximide, gentamicin, lithium, lignocaine, netilmicin, paracetamol, phenobarbitone, primidone, phenytoin, procainamide, quinidine, salicylate, theophylline, tobramycin, valproate or vancomycin - 1 test (Item to be subject to rule 6) *(See para PP. of explanatory notes to this Category)* **Fee:** $18.45	**Benefit:** 75% $13.85	85% $15.70
66803	2 tests described in item 66800 (Item is subject to rule 6) **Fee:** $31.05	**Benefit:** 75% $23.30	85% $26.40
66806	3 tests described in item 66800 (Item is subject to rule 6) **Fee:** $43.60	**Benefit:** 75% $32.70	85% $37.10
66809	Tests described in item 66800, if rendered under a request referred to in subparagraph (2) (a) (iii) of rule 6 - each test to a maximum of 2 tests (Item is subject to rule 6) **Fee:** $12.60	**Benefit:** 75% $9.45	85% $10.75
66812	Quantitation, not elsewhere described in this Table by any method or methods, in blood, urine or other body fluid, of a drug being used therapeutically by the patient from whom the specimen was taken - 1 test (This fee applies where 1 laboratory performs the only test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) *(See para PP. of explanatory notes to this Category)* **Fee:** $35.45	**Benefit:** 75% $26.60	85% $30.15
66815	2 tests described in item 66812 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $60.60	**Benefit:** 75% $45.45	85% $51.55
66818	Tests described in item 66812, if rendered under a request referred to in subparagraph (2) (a) (iii) of rule 6 - each test to a maximum of 1 test (Item is subject to rule 6) **Fee:** $25.15	**Benefit:** 75% $18.90	85% $21.40

GROUP P3 - MICROBIOLOGY

69300	Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including: (a) differential cell count (if performed);or (b) examination for dermatophytes;or (c) dark ground illumination;or (d) stained preparation or preparations using any relevant stain or stains; 1 or more tests **Fee:** $12.60	**Benefit:** 75% $9.45	85% $10.75
I 69303	Culture and (if performed) microscopy to detect pathogenic micro-organisms from nasal swabs, throat swabs, eye swabs and ear swabs (excluding swabs taken for epidemiological surveillance), including (if performed): (a) pathogen identification and antibiotic susceptibility testing;or (b) a service described in item 69300; specimens from 1 or more sites **Fee:** $32.15	**Benefit:** 75% $36.65	85% $38.85
I 69306	Microscopy and culture to detect pathogenic micro-organisms from skin or other superficial sites, including (if performed): (a) pathogen identification and antibiotic susceptibility testing;or (b) a service described in items 69300, 69303, 69312, 69318; 1 or more tests on 1 or more specimens **Fee:** $34.00	**Benefit:** 75% $35.50	85% $38.90
I 69309	Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Table;or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens **Fee:** $38.45	**Benefit:** 75% $36.35	85% $41.20
I 69312	Microscopy and culture to detect pathogenic micro-organisms from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed): (a) pathogen identification and antibiotic susceptibility testing;or (b) a service described in items 69300, 69303, 69306 and 69318; 1 or more tests on 1 or more specimens **Fee:** $34.00	**Benefit:** 75% $35.50	85% $38.90
I 69318	Microscopy and culture to detect pathogenic micro-organisms from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed): (a) pathogen identification and antibiotic susceptibility testing;or (b) a service described in items 69300, 69303, 69306 and 69312; 1 or more tests on 1 or more specimens **Fee:** $34.00	**Benefit:** 75% $35.50	85% $38.90
I 69321	Microscopy and culture of post-operative wounds, aspirates of body cavities, synovial fluid, CSF or operative or biopsy specimens, for the presence of pathogenic micro-organisms involving aerobic and anaerobic cultures and the use of different culture media, and including (if performed): (a) pathogen identification and antibiotic susceptibility testing;or (b) a service described in item 69300, 69303, 69306, 69312 or 69318; specimens from 1 or more sites **Fee:** $38.45	**Benefit:** 75% $36.35	85% $41.20
69324	Microscopy (with appropriate stains) and culture for mycobacteria - 1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure;or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $43.30	**Benefit:** 75% $32.50	85% $36.85
69327	Microscopy (with appropriate stains) and culture for mycobacteria - 2 specimens of sputum, urine, or other body fluid or 2 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure;or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $85.55	**Benefit:** 75% $64.20	85% $72.75

69330	Microscopy (with appropriate stains) and culture for mycobacteria - 3 specimens of sputum, urine, or other body fluid or 3 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure;or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $28.85	**Benefit:** 75% $86.65	85% $109.55
69333	Urine examination (including serial examination) by any means other than simple culture by dip slide, including: (a) cell count;and (b) culture;and (c) colony count;and (d) (if performed) stained preparations;and (e) (if performed) identification of cultured pathogens;and (f) (if performed) antibiotic suseptibility testing;and (g) (if performed) examination for pH, specific gravity, blood, albumin, urobilinogen, sugar, acetone or bile salts **Fee:** $30.70	**Benefit:** 75% $85.55	85% $87.60
69336	Microscopy of faeces for ova, cysts and parasites that must include a concentration technique, and the use of fixed stains or antigen detection for cryptosporidia and giardia - including (if performed) a service mentioned in item 69300 - 1 of this item in any 7 day period **Fee:** $33.65	**Benefit:** 75% $85.25	85% $88.65
69339	Microscopy of faeces for ova, cysts and parasites using concentration techniques examined subsequent to item 69336 on a separately collected and identified specimen collected within 7 days of the examination described in 69336 - 1 examination in any 7 day period **Fee:** $29.25	**Benefit:** 75% $84.45	85% $86.40
69345	Culture and (if performed) microscopy without concentration techniques of faeces for faecal pathogens, using at least 2 selective or enrichment media and culture in at least 2 different atmospheres including (if performed): (a) pathogen identification and antibiotic susceptibility testing;and (b) the detection of clostridial toxins;and (c) a service described in item 69300; - 1 examination in any 7 day period **Fee:** $33.25	**Benefit:** 75% $89.95	85% $85.30
69354	Blood culture for pathogenic micro-organisms (other than viruses), including sub-cultures and (if performed): (a) identification of any cultured pathogen; and (b) necessary antibiotic susceptibility testing; to a maximum of 3 sets of cultures - 1 set of cultures **Fee:** $30.95	**Benefit:** 75% $83.25	85% $86.35
69357	2 sets of cultures described in item 69354 **Fee:** $61.85	**Benefit:** 75% $86.40	85% $52.60
69360	3 sets of cultures described in item 69354 **Fee:** $92.80	**Benefit:** 75% $69.60	85% $78.90
I 69363	Detection of *Clostridium difficile* or *Clostridium difficile* toxin (except if a service described in items 69345, 69369, 69370, 69373 or 69375 has been performed) - 1 or more tests **Fee:** $38.85	**Benefit:** 75% $81.65	85% $84.55
H 69364	Detection of a virus or microbial nucleic acid (not elsewhere specified) 1 test (Item is subjuect to rule 25) **Fee:** $38.85	**Benefit:** 75% $81.65	85% $84.55
H 69365	2 or more tests described in 69453 (Item is subject to rule 25) **Fee:** $6.10	**Benefit:** 75% $87.10	85% $80.70
69378	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of a HIV sero-positive patient not on antiretroviral therapy - 1 or more tests on 1 or more specimens **Fee:** $81.45	**Benefit:** 75% $36.10	85% $54.25

69381	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of antiretroviral therapy in a HIV sero-positive patient - 1 or more tests on 1 or more specimens **Fee:** $81.45	**Benefit:** 75% $36.10	85% $54.25
69382	Quantitation of HIV viral RNA load in cerebrospinal fluid in a HIV sero-positive patient - 1 or more tests on 1 or more specimens **Fee:** $81.45	**Benefit:** 75% $36.10	85% $54.25
69384	Quantitation of 1 antibody to microbial or exogenous antigens not elsewhere described in the Schedule - 1 test (This fee applies where a laboratory performs the only antibody test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) *(See para PP. of explanatory notes to this Category)* **Fee:** $5.75	**Benefit:** 75% $1.85	85% $3.40
69387	2 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 estimations specified on the request form or performs 2 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) *(See para PP. of explanatory notes to this Category)* **Fee:** $8.85	**Benefit:** 75% $1.65	85% $4.55
69390	3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) *(See para PP. of explanatory notes to this Category)* **Fee:** $13.30	**Benefit:** 75% $2.50	85% $6.85
69393	4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 estimations specified on the request form or performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) *(See para PP. of explanatory notes to this Category)* **Fee:** $17.75	**Benefit:** 75% $3.35	85% $9.10
69396	5 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 estimations specified on the request form or performs 5 of the antibody tests specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) *(See para PP. of explanatory notes to this Category)* **Fee:** $22.15	**Benefit:** 75% $4.15	85% $11.35
69399	6 or more tests described in item 69384 *(See para PP. of explanatory notes to this Category)* **Fee:** $26.60	**Benefit:** 75% $4.95	85% $13.65
69402	Tests described in item 69384, if rendered under a request referred to in subparagraph (2) (a) (iii) of rule 6 - each test to a maximum of 5 tests (Item is subject to rule 6) **Fee:** $4.45	**Benefit:** 75% $0.85	85% $2.30
I 69405	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 1 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 *(See para PP. of explanatory notes to this Category)* **Fee:** $5.75	**Benefit:** 75% $1.85	85% $3.40

	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 2 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481
I	*(See para PP. of explanatory notes to this Category)*
69408	**Fee:** $38.00 **Benefit:** 75% $31.00 85% $33.80
	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 3 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481
I	*(See para PP. of explanatory notes to this Category)*
69411	**Fee:** $39.35 **Benefit:** 75% $29.55 85% $33.45
	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 4 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481
I	*(See para PP. of explanatory notes to this Category)*
69413	**Fee:** $40.65 **Benefit:** 75% $28.00 85% $33.10
	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of all 5 of the following - rubella immune status, specific syphillis serology, carriage of Hepatitus B, Hepatitus C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481
H	(See para PP. of explanatory notes to this Category)
69415	Fee: $51.95 Benefit:75% $36.50 85% $42.70
	Quantitation of HCV RNA load in plasma or serum in the pretreatment evaluation or the assessment of efficacy of antiviral therapy of a patient with chronic HCV hepatitis - where any request for the test is made by or on the advice of the specialist or consultant physician who manages the treatment of the patient with chronic HCV hepatitis (including a service in item 69444 or 69445) - To a maximum of 2 of this item in a 12 month period
69442	**Fee:** $81.45 **Benefit:** 75% $36.10 85% $54.25
	Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if: (a) the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis;and (b) the request for the test is made by, or on the advice of, the specialist or consultant physician managing the treatment of the patient; To a maximum of 1 of this item in a 12 month period
69443	**Fee:** $306.20 **Benefit:** 75% $154.65 85% $175.30
	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; To a maximum of 1 of this item in a 12 month period (Item is subject to rule 19)
69444	**Fee:** $92.80 **Benefit:** 75% $69.60 85% $78.90
	Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69444) - 1 test. To a maximum of 4 of this item in a 12 month period (Item is subject to rule 19)
69445	**Fee:** $92.80 **Benefit:** 75% $69.60 85% $78.90
	Test of cell-mediated immunity in blood for the detection of active tuberculosis or atypical mycobacterial infection in an immunosuppressed or immunocompromised patient - 1 test
69471	**Fee:** $35.15 **Benefit:** 75% $26.40 85% $29.90

69472	Detection of antibodies to Epstein Barr Virus using specific serology - 1 test **Fee:** $5.75 **Benefit:** 75% $1.85 85% $3.40
69474	Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests **Fee:** $8.85 **Benefit:** 75% $1.65 85% $4.55
69475	One test for hepatitis antigen or antibodies to determine immune status or viral carriage following exposure or vaccination to Hepatitis A, Hepatitis B, Hepatitis C or Hepatitis D including: (a) One test for antibodies to Hepatitis A;or (b) One test for antibodies to or antigens of Hepatitis B;or (c) One test for antibodies to Hepatitis C;or (d) One test for antibodies to Hepatitis D in a patient who is Hepatitis B surface antigen positive (Item subject to rule 11) **Fee:** $5.75 **Benefit:** 75% $1.85 85% $3.40
69478	Two tests for hepatitis antigens or antibodies to determine immune status or viral carriage following exposure to, or vaccination to Hepatitis A, Hepatitis B, Hepatitis C or Hepatitis D including: (a) One test for antibodies to Hepatitis A;or (b) One test for surface or core antibodies to Hepatitis B;or (c) One test for surface antigen of Hepatitis B;or (d) One test for 'e' antibodies to or 'e' antigen of Hepatitis B;or (e) One test for antibodies to Hepatitis C;or (f) One test for antibodies to Hepatitis D in a patient who is Hepatitis B surface antigen positive (Item subject to rule 11) **Fee:** $9.45 **Benefit:** 75% $2.10 85% $5.05
69481	Three tests for the investigation of infectious causes of acute or chronic hepatitis including: (a) One test for antibodies to Hepatitis A;or (b) One test for core antibodies to Hepatitis B;or (c) One test for 'e' antibodies to or 'e' antigens of Hepatitis B;or (d) One test for surface antibodies to or surface antigen of Hepatitis B;or (e) One test for antibodies to Hepatitis C;or (f) One test for antibodies to Hepatitis D in a patient who is Hepatitis B surface antigen positive (Item subject to rule 11) *(See para PP. of explanatory notes to this Category)* **Fee:** $10.80 **Benefit:** 75% $0.60 85% $4.70
69484	Supplementary testing for Hepatitis B surface antigen or Hepatitis C antibody using a different assay on the specimen which yielded a reactive result on initial testing (Item is not subject to rule 11) **Fee:** $7.20 **Benefit:** 75% $2.90 85% $4.65
H 69486	A test for high risk human papillomaviruses (HPV) in a patient who: - has received excisional or ablative treatment for high grade intraepithelial abnormalities of the cervix within the last two years;or - who within the last two years has had a positive HPV test after excisional or ablative treatment for high grade intraepithelial abnormalities of the cervix - to a maximum of 2 of this item in a 24 month period Fee: $4.00 Benefit: 75% $8.00 85% $4.40

GROUP P4 - IMMUNOLOGY

71057	Electrophoresis, quantitative and qualitative, of serum, urine or other body fluid all collected within a 28 day period, to demonstrate: (a) protein classes;or (b) presence and amount of paraprotein; including the preliminary quantitation of total protein, albumin and globulin - 1 specimen type **Fee:** $36.30	**Benefit:** 75% $27.25	85% $30.90
71058	Examination as described in item 71057 of 2 or more specimen types **Fee:** $11.40	**Benefit:** 75% $8.55	85% $9.70
71059	Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of: (a) urine for detection of Bence Jones proteins;or (b) serum, plasma or other body fluid; and characterisation, if detected, of a paraprotein or cryoglobulin not previously characterised - examination of 1 specimen type (eg. serum, urine or CSF) **Fee:** $39.70	**Benefit:** 75% $32.30	85% $35.25
71060	Examination as described in item 71059 of 2 or more specimen types **Fee:** $44.80	**Benefit:** 75% $33.60	85% $38.10
71062	Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of CSF for the detection of oligoclonal bands and including if required electrophoresis of the patient's serum for comparison purposes - 1 or more tests **Fee:** $44.80	**Benefit:** 75% $33.60	85% $38.10
71064	Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests **Fee:** $21.10	**Benefit:** 75% $15.85	85% $17.95
71066	Quantitation of total immunoglobulin A by any method in serum, urine or other body fluid - 1 test **Fee:** $14.80	**Benefit:** 75% $11.10	85% $12.60
71068	Quantitation of total immunoglobulin G by any method in serum, urine or other body fluid - 1 test **Fee:** $14.80	**Benefit:** 75% $11.10	85% $12.60
71069	2 tests described in items 71066, 71068, 71072 or 71074 **Fee:** $23.15	**Benefit:** 75% $17.40	85% $19.70
71071	3 or more tests described in items 71066, 71068, 71072 or 71074 **Fee:** $31.50	**Benefit:** 75% $23.65	85% $26.80
71072	Quantitation of total immunoglobulin M by any method in serum, urine or other body fluid - 1 test **Fee:** $14.80	**Benefit:** 75% $11.10	85% $12.60
71073	Quantitation of all 4 immunoglobulin G subclasses **Fee:** $108.00	**Benefit:** 75% $81.00	85% $91.80
71074	Quantitation of total immunoglobulin D by any method in serum, urine or other body fluid - 1 test **Fee:** $14.80	**Benefit:** 75% $11.10	85% $12.60
71075	Quantitation of immunoglobulin E (total), 1 test. To a maximum of 2 of this item in a 12 month period **Fee:** $23.40	**Benefit:** 75% $17.55	85% $19.90
71077	Quantitation of immunoglobulin E (total) in the follow up of a patient with proven immunoglobulin-E-secreting myeloma, proven congenital immunodeficiency or proven allergic bronchopulmonary aspergillosis, 1 test. To a maximum of 6 of this item in a 12 month period **Fee:** $27.55	**Benefit:** 75% $20.70	85% $23.45
71079	Detection of specific immunoglobulin G or E antibodies to single or multiple potential allergens, 1 of this item to a maximum of 4 in a 12 month period **Fee:** $27.30	**Benefit:** 75% $20.50	85% $23.25
71081	Quantitation of total haemolytic complement **Fee:** $41.25	**Benefit:** 75% $30.95	85% $35.10
71083	Quantitation of complement components C3 and C4 or properdin factor B - 1 test **Fee:** $20.50	**Benefit:** 75% $15.40	85% $17.45

71085	2 tests described in item 71083 **Fee:** $9.45	**Benefit:** 75% $2.10	85% $5.05
71087	3 or more tests described in item 71083 **Fee:** $8.35	**Benefit:** 75% $8.80	85% $2.60
71089	Quantitation of complement components or breakdown products of complement proteins not elsewhere described in an item in this Schedule - 1 test **Fee:** $9.65	**Benefit:** 75% $2.25	85% $5.25
71091	2 tests described in item 71089 **Fee:** $3.70	**Benefit:** 75% $0.30	85% $5.65
71093	3 or more tests described in item 71089 **Fee:** $7.80	**Benefit:** 75% $8.35	85% $6.15
71095	Quantitation of serum or plasma eosinophil cationic protein, or both, to a maximum of 3 assays in 1 year, for monitoring the response to therapy in corticosteroid treated asthma, in a child aged less than 12 years *(See para PP. of explanatory notes to this Category)* **Fee:** $11.25	**Benefit:** 75% $0.95	85% $5.10
71097	Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required **Fee:** $4.85	**Benefit:** 75% $8.65	85% $1.15
71099	Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method **Fee:** $7.00	**Benefit:** 75% $0.25	85% $2.95
71101	Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids **Fee:** $7.70	**Benefit:** 75% $3.30	85% $5.05
71103	Characterisation of an antibody detected in a service described in item 71101 (including that service) **Fee:** $2.95	**Benefit:** 75% $9.75	85% $5.05
71106	Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required **Fee:** $1.50	**Benefit:** 75% $8.65	85% $9.80
71109	Antibodies to tissue antigens (acetylcholine receptor, adrenal cortex, cardiolipin, heart, histone, insulin, insulin receptor, intrinsic factor, islet cell, lymphocyte, neuron, ovary, parathyroid, platelet, salivary gland, skeletal muscle, skin basement membrane and intercellular substance, thyroglobulin, thyroid microsome or thyroid stimulating hormone receptor) - detection, including quantitation if required, of 1 antibody **Fee:** $5.15	**Benefit:** 75% $6.40	85% $9.90
71113	Detection of 2 antibodies described in item 71109 **Fee:** $8.25	**Benefit:** 75% $6.20	85% $1.05
71115	Detection of 3 antibodies described in item 71109 **Fee:** $1.35	**Benefit:** 75% $6.05	85% $2.15
71117	Detection of 4 or more antibodies described in item 71109 **Fee:** $4.45	**Benefit:** 75% $5.85	85% $3.30
71119	Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody **Fee:** $7.65	**Benefit:** 75% $3.25	85% $5.05
71121	Detection of 2 antibodies specified in item 71119 **Fee:** $1.15	**Benefit:** 75% $5.90	85% $8.00
71123	Detection of 3 antibodies specified in item 71119 **Fee:** $4.65	**Benefit:** 75% $8.50	85% $1.00
71125	Detection of 4 or more antibodies specified in item 71119 **Fee:** $8.15	**Benefit:** 75% $1.15	85% $3.95

	Functional tests for lymphocytes - quantitation other than by microscopy of: (a) proliferation induced by 1 or more mitogens;or (b) proliferation induced by 1 or more antigens;or (c) estimation of 1 or more mixed lymphocyte reactions; including a test described in item 65066 or 65070 (if performed), 1 of this item to a maximum of 2 in a 12 month period		
71127	**Fee:** $79.45	**Benefit:** 75% $34.60	85% $52.55
	2 tests described in item 71127		
71129	**Fee:** $121.65	**Benefit:** 75% $66.25	85% $88.45
	3 or more tests described in item 71127		
71131	**Fee:** $163.90	**Benefit:** 75% $97.95	85% $124.35
	Investigation of recurrent infection by qualitative assessment for the presence of defects in oxidative pathways in neutrophils by the nitroblue tetrazolium (NBT) reduction test		
71133	**Fee:** $0.55	**Benefit:** 75% $.95	85% $.00
	Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed)		
71134	**Fee:** $105.85	**Benefit:** 75% $59.40	85% $80.00
	Quantitation of neutrophil function, comprising at least 2 of the following: (a) chemotaxis; (b) phagocytosis; (c) oxidative metabolism; (d) bactericidal activity; including any test described in items 65066, 65070, 71133 or 71134 (if performed), 1 of this item to a maximum of 2 in a 12 month period		
71135	**Fee:** $211.60	**Benefit:** 75% $158.70	85% $179.90
	Quantitation of cell-mediated immunity by multiple antigen delayed type hypersensitivity intradermal skin testing using a minimum of 7 antigens, 1 of this item to a maximum of 2 in a 12 month period		
71137	**Fee:** $0.80	**Benefit:** 75% $3.10	85% $6.20
	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		
71139	**Fee:** $105.85	**Benefit:** 75% $79.40	85% $90.00
	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations on 1 or more disaggregated tissue specimens		
71141	**Fee:** $200.85	**Benefit:** 75% $150.65	85% $170.75
	Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or both of items 71139 and 71141 (if performed), on a specimen of blood, CSF, serous fluid or disaggregated tissue		
71143	**Fee:** $264.55	**Benefit:** 75% $198.45	85% $224.90
	Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or more of items 71139, 71141 and 71143 (if performed), on 2 or more specimens of disaggregated tissues or 1 specimen of disaggregated tissue and 1 or more specimens of blood, CSF or serous fluid		
71145	**Fee:** $331.95	**Benefit:** 75% $249.00	85% $282.15
	Enumeration of CD34+ cells, only for the purposes of autologous or directed allogeneic haemopoietic stem cell transplantation, including a total white cell count		
71146	**Fee:** $105.85	**Benefit:** 75% $79.40	85% $90.00
	HLA-B27 typing		
71147	**Fee:** $41.25	**Benefit:** 75% $30.95	85% $35.10
	Complete tissue typing for 4 HLA-A and HLA-B Class I antigens (including any separation of leucocytes), including (if performed) a service described in item 71147		
71149	**Fee:** $110.15	**Benefit:** 75% $82.65	85% $93.65

71151	Tissue typing for HLA-DR, HLA-DP and HLA-DQ Class II antigens (including any separation of leucocytes) - phenotyping or genotyping of 2 or more antigens **Fee:** $120.95	**Benefit:** 75% $90.75	85% $102.85
71153	Investigations in the assessment or diagnosis of systemic inflammatory disease or vasculitis - antineutrophil cytoplasmic antibody immunofluorescence (ANCA test), antineutrophil proteinase 3 antibody (PR-3 ANCA test), antimyeloperoxidase antibody (MPO ANCA test) or antiglomerular basement membrane antibody (GBM test) - detection of 1 antibody (Item is subject to rule 23) **Fee:** $35.15	**Benefit:** 75% $26.40	85% $29.90
71155	Detection of 2 antibodies described in item 71153 (Item is subject to rule 23) **Fee:** $48.25	**Benefit:** 75% $36.20	85% $41.05
71157	Detection of 3 antibodies described in item 71153 (Item is subject to rule 23) **Fee:** $61.35	**Benefit:** 75% $46.05	85% $52.15
71159	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 23) **Fee:** $74.45	**Benefit:** 75% $55.85	85% $63.30
71163	Detection of one of the following antibodies (of 1 or more class or isotype) in the assessment or diagnosis of coeliac disease or other gluten hypersensitivity syndromes and including a service described in item 71066 (if performed): a) Antibodies to gliadin;or b) Antibodies to endomysium;or c) Antibodies to tissue transglutaminase; One test **Fee:** $35.15	**Benefit:** 75% $38.90	85% $41.40
71164	Two or more tests described in 71163 and including a service described in 71066 (if performed) **Fee:** $80.60	**Benefit:** 75% $60.45	85% $64.55

GROUP P5 - TISSUE PATHOLOGY

72813	Examination of complexity level 2 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) **Fee:** $42.15	**Benefit:** 75% $54.15	85% $61.35
72816	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13) **Fee:** $47.10	**Benefit:** 75% $65.35	85% $74.05
72817	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13) **Fee:** $57.45	**Benefit:** 75% $73.10	85% $82.85
72818	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 or more separately identified specimens (Item is subject to rule 13) **Fee:** $107.75	**Benefit:** 75% $80.85	85% $91.60
72823	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13) **Fee:** $67.95	**Benefit:** 75% $73.50	85% $83.30
72824	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13) **Fee:** $42.30	**Benefit:** 75% $106.75	85% $121.00
72825	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 to 7 separately identified specimens (Item is subject to rule 13) **Fee:** $81.45	**Benefit:** 75% $136.10	85% $154.25
72826	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 8 or more separately identified specimens (Item is subject to rule 13) **Fee:** $95.90	**Benefit:** 75% $146.95	85% $166.55
72830	Examination of complexity level 5 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) **Fee:** $90.75	**Benefit:** 75% $143.10	85% $162.15
72836	Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) **Fee:** $93.85	**Benefit:** 75% $120.40	85% $149.80
72844	Enzyme histochemistry of skeletal muscle for investigation of primary degenerative or metabolic muscle diseases or of muscle abnormalities secondary to disease of the central or peripheral nervous system - 1 or more tests **Fee:** $0.95	**Benefit:** 75% $3.25	85% $6.35

PATHOLOGY				PATHOLOGY
72846	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 72848 (Item is subject to rule 13) **Fee:** $43.30	**Benefit:** 75% $32.50	85% $36.85	
72847	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 or more antibodies (Item is subject to rule 13) **Fee:** $57.75	**Benefit:** 75% $43.35	85% $49.10	
72848	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 of the following antibodies - oestrogen, progesterone and c-erb-B2 (HER2) (Item is subject to rule 13) **Fee:** $51.55	**Benefit:** 75% $38.70	85% $43.85	
72851	Electron microscopic examination of biopsy material - 1 separately identified specimen (Item is subject to rule 13) **Fee:** $85.60	**Benefit:** 75% $39.20	85% $57.80	
72852	Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 13) **Fee:** $147.45	**Benefit:** 75% $85.60	85% $110.35	
72855	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 1 separately identified specimen (Item is subject to rule 13) **Fee:** $85.60	**Benefit:** 75% $39.20	85% $57.80	
72856	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 2 to 4 separately identified specimens (Item is subject to rule 13) **Fee:** $147.45	**Benefit:** 75% $85.60	85% $110.35	
72857	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 5 or more separately identified specimens (Item is subject to rule 13) **Fee:** $188.70	**Benefit:** 75% $116.55	85% $145.40	

GROUP P6 - CYTOLOGY

73043	Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes 1 or more tests **Fee:** $13.00 **Benefit:** 75% $7.25 85% $9.55
73045	Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73053);and including any Group P5 service, if performed on: (a) specimens resulting from washings or brushings from sites not specified in item 73043;or (b) a single specimen of sputum or urine;or (c) 1 or more specimens of other body fluids; 1 or more tests **Fee:** $8.95 **Benefit:** 75% $6.75 85% $1.65
73047	Cytology of a series of 3 sputum or urine specimens for malignant cells **Fee:** $5.35 **Benefit:** 75% $1.55 85% $1.05
73049	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues **Fee:** $9.60 **Benefit:** 75% $2.20 85% $9.20
73051	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues if: (a) the aspiration is performed by a recognised pathologist;or (b) a recognised pathologist attends the aspiration and performs cytological examination during the attendance **Fee:** $71.50 **Benefit:** 75% $28.65 85% $45.80
73053	Cytology of a smear from cervix where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each examination (a) for the detection of precancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia, or (b) if a further specimen is taken due to an unsatisfactory smear taken for the purposes of paragraph (a);or (c) if there is inadequate information provided to use item 73055; *(See para PP. of explanatory notes to this Category)* **Fee:** $9.60 **Benefit:** 75% $4.70 85% $6.70
73055	Cytology of a smear from cervix, not associated with item 73053, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test (a) for the management of previously detected abnormalities including precancerous or cancerous conditions;or (b) for the investigation of women with symptoms, signs or recent history suggestive of cervical neoplasia; *(See para PP. of explanatory notes to this Category)* **Fee:** $9.60 **Benefit:** 75% $4.70 85% $6.70
73057	Cytology of smears from vagina, not associated with item 73053 or 73055 and not to monitor hormone replacement therapy, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test *(See para PP. of explanatory notes to this Category)* **Fee:** $9.60 **Benefit:** 75% $4.70 85% $6.70
73059	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 73061 (Item is subject to rule 13) **Fee:** $13.30 **Benefit:** 75% $2.50 85% $6.85
73060	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 or more antibodies (Item is subject to rule 13) **Fee:** $7.75 **Benefit:** 75% $3.35 85% $9.10
73061	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 of the following antibodies - oestrogen, progesterone and c-erb-B2 (HER2) (Item is subject to rule 13) **Fee:** $1.55 **Benefit:** 75% $8.70 85% $3.85

	GROUP P7 - GENETICS
73287	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques of 1 or more of any tissue or fluid except blood - 1 or more tests **Fee:** $401.45 **Benefit:** 75% $301.10 85% $341.25
73289	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques of blood - 1 or more tests **Fee:** $65.20 **Benefit:** 75% $73.90 85% $10.45
73300	Detection of genetic mutation of the FMR1 gene by nucleic acid amplification (NAA) where: (a) the patient exhibits one or more of the clinical features of fragile X (A) syndrome, including intellectual disabilities;o r (b) the patient has a relative with a fragile X (A) mutation 1 or more tests *(See para PP. of explanatory notes to this Category)* **Fee:** $103.10 **Benefit:** 75% $77.35 85% $87.65
73305	Detection of genetic mutation of the FMR1 gene by Southern Blot where the results in item 73300 are inconclusive *(See para PP. of explanatory notes to this Category)* **Fee:** $306.20 **Benefit:** 75% $154.65 85% $175.30
	GROUP P8 - INFERTILITY AND PREGNANCY TESTS
73521	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test) **Fee:** $9.80 **Benefit:** 75% $8.35 85% $8.35
73523	Semen examination (other than post-vasectomy semen examination), including: (a) measurement of volume, sperm count and motility;and (b) examination of stained preparations;and (c) morphology;and (if performed) (d) differential count and 1 or more chemical tests; 1 of this item to a maximum of 4 in a 12 month period **Fee:** $42.50 **Benefit:** 75% $31.90 85% $36.15
73525	Sperm antibodies - sperm-penetrating ability - 1 or more tests **Fee:** $38.85 **Benefit:** 75% $31.65 85% $34.55
73527	Human chorionic gonadotrophin (HCG) - detection in serum or urine by 1 or more methods for diagnosis of pregnancy - 1 or more tests **Fee:** $10.20 **Benefit:** 75% $8.65 85% $8.70
73529	Human chorionic gonadotrophin (HCG), quantitation in serum by 1 or more methods (except by latex, membrane, strip or other pregnancy test kit) for diagnosis of threatened abortion, or followup of abortion or diagnosis of ectopic pregnancy, including any services performed in item 73527 - 1 test **Fee:** $39.15 **Benefit:** 75% $31.90 85% $34.80
	GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS
73801	***Para PA.2.1 of the explanatory notes refers to all items in Group P9.*** Semen examination for presence of spermatozoa **Fee:** $6.95 **Benefit:** 75% $5.25 85% $5.95
73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count - 1 test **Fee:** $4.60 **Benefit:** 75% $3.45 85% $3.95
73803	2 tests described in item 73802 **Fee:** $6.40 **Benefit:** 75% $4.80 85% $5.45
73804	3 or more tests described in item 73802 **Fee:** $8.20 **Benefit:** 75% $6.15 85% $7.00

73805	Microscopy of urine, whether stained or not, or catalase test **Fee:** $4.60	**Benefit:** 75% $3.45	85% $3.95
73806	Pregnancy test by 1 or more immunochemical methods **Fee:** $10.20	**Benefit:** 75% $7.65	85% $8.70
73807	Microscopy for wet film other than urine, including any relevant stain **Fee:** $6.95	**Benefit:** 75% $5.25	85% $5.95
73808	Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807 **Fee:** $8.70	**Benefit:** 75% $6.55	85% $7.40
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method **Fee:** $3.35	**Benefit:** 75% $2.80	85% $3.00
73810	Microscopy for fungi in skin, hair or nails - 1 or more sites **Fee:** $6.95	**Benefit:** 75% $5.25	85% $5.95
73811	Mantoux test **Fee:** $11.30	**Benefit:** 75% $8.50	85% $9.65

	GROUP P10 - PATIENT EPISODE INITIATION
73901	Initiation of a patient episode that consists only of a service described in item 73053, 73055 or 73057 from a person who is not in a recognised hospital or a prescribed laboratory **Fee:** $8.25 **Benefit:** 75% $6.20 85% $7.05
73903	Initiation of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 from a person who is an in-patient of a hospital other than a recognised hospital **Fee:** $4.75 **Benefit:** 75% $1.10 85% $2.55
73905	Initiation of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 from a person who is not an in-patient of a private hospital and not a patient of a recognised hospital **Fee:** $8.25 **Benefit:** 75% $6.20 85% $7.05
73907	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903, 73905 or in Group P9) if the specimen is collected in an approved collection centre **Fee:** $7.40 **Benefit:** 75% $3.05 85% $4.80
73909	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903, 73905 or in Group P9) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person who is an in-patient of a hospital other than a recognised hospital **Fee:** $7.70 **Benefit:** 75% $3.30 85% $5.05
73910	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903 or 73905 or in Group P9) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in the place where the person was residing **Fee:** $0.30 **Benefit:** 75% $.75 85% $.80
73912	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903 or 73905 or in Group P9) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in a residential aged care home or institution **Fee:** $7.70 **Benefit:** 75% $3.30 85% $5.05
73913	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903, 73905 or 73907 or items in Group P9) if the specimen is collected from the person by the person **Fee:** $1.80 **Benefit:** 75% $.35 85% $.35
73915	Initiation of a patient episode by collection of a specimen for a service (other than a service described in items 73901, 73903 or 73905 or items in Group P9) if the specimen is collected by or on behalf of the treating practitioner **Fee:** $1.80 **Benefit:** 75% $.35 85% $.35
	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:** $0.30 **Benefit:** 75% $.75 85% $.80

GROUP P12 - MANAGEMENT OF BULK-BILLED SERVICES

74990

A pathology service to which an item in this table (other than this item or item 74991) applies if:

(a) the service is an unreferred service;and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital or day-hospital facility;and

(d) the service is bulk-billed in respect of the fees for:

(i) this item;and

(ii) the other item in this table applying to the service

(See para PP. of explanatory notes to this Category)

Fee: $6.05 **Benefit:** 85% $5.15

74991

A pathology service to which an item in this table (other than this item or item 74990) applies if:

(a) the service is an unreferred service;and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital or day-hospital facility;and

(d) the service is bulk-billed in respect of the fees for:

(i) this item;and

(ii) the other item in this table applying to the service;and

(e) the service is provided at, or from, a practice location in:

(i) a regional, rural or remote area;or

(ii) Tasmania;or

(iii) A geographical area included in any of the following SSD spatial units:

(A) Beaudesert Shire Part A
(B) Belconnen
(C) Darwin City
(D) Eastern Outer Melbourne
(E) East Metropolitan
(F) Frankston City
(G) Gosford-Wyong
(H) Greater Geelong City Part A
(I) Gungahlin-Hall
(J) Ipswich City (part in BSD)
(K) Litchfield Shire
(L) Melton-Wyndham
(M) Mornington Peninsula Shire
(N) Newcastle
(O) North Canberra
(P) Palmerston-East Arm
(Q) Pine Rivers Shire
(R) Queanbeyan
(S) South Canberra
(T) South Eastern Outer Melbourne
(U) Southern Adelaide
(V) South West Metropolitan
(W) Thuringowa City Part A
(X) Townsville City Part A
(Y) Tuggeranong
(Z) Weston Creek-Stromlo
(ZA) Woden Valley
(ZB) Yarra Ranges Shire Part A;or

(iv) the geographical area included in the SLA spatial unit of Palm Island (AC)

(See para PP. of explanatory notes to this Category)

Fee: $9.20 **Benefit:** 85% $7.85

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PATHOLOGY SERVICES

(ABBREVIATIONS)

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Hydroxychloroquine	HOCQ	66812
Hydroxyindoleacetic acid	HIAA	66779
Hydroxyprogesterone	OHP	66695
Hydroxyproline	HYDP	66752
Imipramine	IMIP	66812
Immediate frozen section diagnosis of biopsy material	FS	72855-56
Immunocyto. 1-3 antibodies	ICC	73059, 73061
Immunocyto. 4+ antibodies	ICC1	73060
Immunoelectrophoresis and electrophoresis – characterisation of cryoglobulins	RYO	71059
Immunoelectrophoresis and electrophoresis – characterisation of paraprotein	PPRO	71059
Immunoglobulins - A	IGA	71066
Immunoglobulins - D	IGD	71074
Immunoglobulins - E (total)	IGE	71075-79
Immunoglobulins - G	IGG	71068
Immunoglobulins - G, 4 subclasses	SIGG	71073
Immunoglobulins - M	IGM	71072
Immunohistochemical investigation of biopsy material	HIS	72846-48
Infectious mononucleosis	IM	69384
Influenza A - microbial antibody testing	FLA	69384
Influenza B - microbial antibody testing	FLB	69384
Insulin	INS	66695
Insulin - tissue antigens - antibodies	AINS	71109
Insulin receptor antibodies - tissue antigens – antibodies	INSA	71109
Intercellular cement substance of skin - tissue antigens - antibodies	ICCS	71109
Intestinal disaccharidases	INTD	66680
Intrinsic factor - tissue antigens - antibodies	AIF	71109
Iron studies (iron, transferrin & ferritin)	IS	66596
Islet cell - tissue antigens - antibodies	AIC	71109
Isoelectric focussing and electrophoresis – characterisation of cryoglobulins	RYO	71059
Isoelectric focussing and electrophoresis – characterisation of paraprotein	PPRO	71059
Jo-1 - tissue antigens - antibodies	JO1	71119
Keratin - tissue antigens - antibodies	KERA	71119
Kleihauer test	KLEI	65162
Lactate	LACT	66500
Lactate - dehydrogenase	LDH	66500
Lactate - dehydrogenase isoenzymes	LDI	66641
Lamellar body phospholipid	LBPH	66749
Lead	PB	66665
Lecithin/sphingomyelin ratio (amniotic fluid)	LS	66749
Legionella pneumophila - serogroup 1 - microbial antibody testing	LP1	69384
Legionella pneumophila - serogroup 2 - microbial antibody testing	LP2	69384
Leishmaniasis - microbial antibody testing	LEI	69384
Leptospira - microbial antibody testing	LEP	69384
Leucocyte count	WCC	65070
Leucocyte count - CD34 surface marker only - blood	LMCD34	71146
Leucocyte count - 3 surface markers - blood, CSF, serous fluid	LMH3	71139
Leucocyte count - 3 surface markers - tissue	LMT3	71141
Leucocyte count - 6 surface markers - blood, CSF, serous fluid & tissue(s)	LMHT	71145
Leucocyte count - 6 surface markers - blood, CSF, serous fluid or tissue	LM6	71143
Lignocaine	LIGN	66800
Lip - cytology on specimens from	SMCY	73043

Lipase	LIP	66500
Lipid studies (see test groups at para PQ.4)	FATS	66500
Lipoprotein subclasses - electrophoresis	LEPG	66539
Listeria - microbial antibody testing	LIS	69384
Lithium	LI	66800
Liver function tests (see test groups at para PQ.4)	LFT	66515
Liver/kidney microsomes - tissue antigens - antibodies	LKA	71119
Lupus anticoagulant	LUPA	65132-37, 65142
Luteinizing hormone	LH	66695
Lymphocyte - tissue antigens - antibodies	ALY	71109
Lymphocytes - functional tests - 1 test	LF1	71127
Lymphocytes - functional tests - 2 tests	LF2	71129
Lymphocytes - functional tests - 3 tests	LF3	71131
Magnesium	MG	66500
Mammary serum antigen	MSA	66650
Manganese	MN	66669-70
Mantoux test	MANT	73811
Measles - microbial antibody testing	MEA	69384
Mercury	HG	66672-73
Metabolic bone disease	CBMB	66776
Methaemalbumin detection (Schumm's test)	SCHM	65117
Metanephrines	MNEP	66779
Methadone	MTDN	66812
Methotrexate	MTTA	66812
Methsuximide	MSUX	66812
Methylphenobarbitone	MPBT	66812
Metronidazole	MRDZ	66812
Mexiletine (Mexitil)	MEX	66812
Mianserin	MIAS	66812
Microalbumin	MALB	66560
Microbial antibody testing - actinomycetes	ACT	69384
Microbial antibody testing - adenovirus	ADE	69384
Microbial antibody testing - aspergillus	ASP	69384
Microbial antibody testing - avian precipitins (bird fancier's disease)	APP	69384
Microbial antibody testing - Blastomyces	BLM	69384
Microbial antibody testing - Bordetella pertussis	BOR	69384
Microbial antibody testing - Borrelia burgdorferi	BOB	69384
Microbial antibody testing - Brucella	BRU	69384
Microbial antibody testing - Campylobacter jejuni	CAM	69384
Microbial antibody testing - Candida	CAN	69384
Microbial antibody testing - Chlamydia	CHL	69384
Microbial antibody testing - Coccidioides	CCC	69384
Microbial antibody testing - Coxsackie B1-6	COX	69384
Microbial antibody testing - cryptococcus	CRY	69384
Microbial antibody testing - cytomegalovirus	CMV	69384
Microbial antibody testing - cytomegalovirus serology in pregnancy	CMVP	69384
Microbial antibody testing - dengue	DEN	69384
Microbial antibody testing - diphtheria	DIP	69384
Microbial antibody testing - echinococcus	ECC	69384
Microbial antibody testing - echo-coxsackie group	ECH	69384
Microbial antibody testing - Entamoeba histolytica	AMO	69384
Microbial antibody testing - Epstein Barr virus	EBV	69472, 69474
Microbial antibody testing - fluorescent treponemal antibody - absorption test (FTA-ABS)	FTA	69384
Microbial antibody testing - Haemophilus influenzae	HUS	69384
Microbial antibody testing - herpes simplex virus	HPA	69384
Microbial antibody testing - Histoplasma	HIP	69384
Microbial antibody testing – Human Immunodeficiency Virus		69384
Microbial antibody testing - hydatid	HYD	69384
Microbial antibody testing - infectious mononucleosis	IM	69384

Microbial antibody testing - influenza A	FLA	69384
Microbial antibody testing - influenza B	FLB	69384
Microbial antibody testing - Legionella pneumophila - serogroup 1	LP1	69384
Microbial antibody testing - Legionella pneumophila - serogroup 2	LP2	69384
Microbial antibody testing - leishmaniasis	LEI	69384
Microbial antibody testing - Leptospira	LEP	69384
Microbial antibody testing - Listeria	LIS	69384
Microbial antibody testing - measles	MEA	69384
Microbial antibody testing - Micropolyspora faeni	MIC	69384
Microbial antibody testing - mumps	MUM	69384
Microbial antibody testing - Murray Valley encephalitis	MVE	69384
Microbial antibody testing - Mycoplasma pneumoniae	MYC	69384
Microbial antibody testing - Neisseria meningitidis	MEN	69384
Microbial antibody testing - Newcastle disease	NCD	69384
Microbial antibody testing - parainfluenza 1	PF1	69384
Microbial antibody testing - parainfluenza 2	PF2	69384
Microbial antibody testing - parainfluenza 3	PF3	69384
Microbial antibody testing - paratyphi	PTY	69384
Microbial antibody testing - pertussis	PER	69384
Microbial antibody testing - poliomyelitis	PLO	69384
Microbial antibody testing - Proteus OX 19	POX	69384
Microbial antibody testing - Proteus OXK	POK	69384
Microbial antibody testing - Q fever	QFF	69384
Microbial antibody testing - rapid plasma reagin test	RPR	69384
Microbial antibody testing - respiratory syncytial virus	RSV	69384
Microbial antibody testing - Ross River virus	RRV	69384
Microbial antibody testing - rubella	RUB	69384
Microbial antibody testing - Salmonella typhi (H)	SAH	69384
Microbial antibody testing - Salmonella typhi (O)	SAO	69384
Microbial antibody testing - Schistosoma	STO	69384
Microbial antibody testing - streptococcal serology - anti-DNASE B titre	ADNB	69384
Microbial antibody testing - streptococcal serology - anti-streptolysin O titre	ASOT	69384
Microbial antibody testing - Streptococcus pneumoniae	PCC	69384
Microbial antibody testing - tetanus	TET	69384
Microbial antibody testing - Thermoactinomyces vulgaris	THE	69384
Microbial antibody testing - thermopolyspora	TPS	69384
Microbial antibody testing - Toxocara	TOC	69384
Microbial antibody testing - toxoplasma	TOX	69384
Microbial antibody testing - TPHA (Treponema pallidum haemagglutination test)	TPHA	69384
Microbial antibody testing - Treponema pallidum haemagglutination test	TPHA	69384
Microbial antibody testing - trichinosis	TOS	69384
Microbial antibody testing - typhus, Weil-Felix	TYP	69384
Microbial antibody testing - Varicella zoster	VCZ	69384
Microbial antibody testing - VDRL (Venereal Disease Research Laboratory)	VDRL	69384
Microbial antibody testing - Yersinia enterocolitica	YER	69384
Microbial antigen testing - Chlamydia	MCCH	69364
Microbial antigen testing - Clostridium difficile	CLDT	69363
Microbial antigen testing - group B streptococcus	STB	69364
Microbial antigen testing - Haemophilus influenzae	HI	69364
Microbial antigen testing - herpes simplex virus	HSV	69364
Microbial antigen testing - Neisseria gonorrhoeae	GON	69364
Microbial antigen testing - Neisseria meningitidis	NMG	69364
Microbial antigen testing - respiratory syncytial virus	RSVN	69364
Microbial antigen testing - Streptococcus pneumoniae	SPN	69364
Microbial antigen testing - Varicella zoster	VCZN	69364
Micropolyspora faeni	MIC	69384
Microscopic examination of - faeces for parasites	OCP	69336-42
Microscopy of wet film material other than blood	MWFM	69300
Microscopy & culture of - material from nose, throat, eye or ear	MCSW	69303
Microscopy & culture of - material from skin	MCSK	69309

Microscopy & culture of - postoperative wounds, aspirates of body cavities	MCPO	69321
Microscopy & culture of - superficial sites	MCSS	69306
Microscopy & culture of - urethra, vagina, cervix or rectum	MCGR	69312
Microscopy & culture of - specimens of sputum	MCSP	69318
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 1 specimen	AFB1	69324
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 2 specimens	AFB2	69327
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 3 specimens	AFB3	69330
Microscopy & culture to detect pathogenic micro-organisms including chlamydia	MCCH	69364
Microscopy, culture, identification & sensitivity of urine	UMCS	69333
Mitochondria - tissue antigens - antibodies	MA	71119
Mouth - cytology on specimens from	SMCY	73043
Mumps - microbial antibody testing	MUM	69384
Murray Valley encephalitis - microbial antibody testing	MVE	69384
Mycobacteria microscopy & culture of sputum - 1 specimen	AFB1	69324
Mycobacteria microscopy & culture of sputum - 2 specimens	AFB2	69327
Mycobacteria microscopy & culture of sputum - 3 specimens	AFB3	69330
Mycoplasma pneumoniae - microbial antibody testing	MYC	69384
Myoglobin	MYOG	66518
N-acetyl procainamide	NAPC	66812
Neisseria gonorrhoeae by NAA techniques and chlamydia by any method	CHGO	69364
Neisseria gonorrhoeae - microbial antigen testing	GON	69364
Neisseria menigitidis - antigens	NMG	69364
Neisseria menigitidis - microbial antibody testing	MEN	69384
Neisseria menigitidis - microbial antigen testing	NMG	69364
Netilmicin		66800
Neural tube defects and Down's syndrome	NTDD	66740
Neuron - tissue antigens - antibodies	ANE	71109
Neutrophil cytoplasm - tissue antigens - antibodies	ANCA	71109
Neutrophil functions	NFT	71135
Newcastle disease - microbial antibody testing	NCD	69384
Nickel	NI	66672-73
Nipple discharge - cytology on specimens from	SMCY	73043
Nitrazepam	NITR	66812
Nordothiepin	NDIP	66812
Norfluoxetine	NFLE	66812
Nortriptyline	NORT	66812
Nose - cytology on specimens from	SMCY	73043
Nose - microscopy & culture of material from	MCSW	69303
Nuclear antigens - detection of antibodies to	ANA	71097
Oestradiol	E2	66695
Oestriol	E3	66740, 66746
Oestrone	E1	66695
Oligoclonal proteins	OGP	71062
Op/biopsy specimens - microscopy & culture of material from	MCPO	69321
Oral glucose challenge test - gestational diabetes	OGCT	66545
Oral glucose tolerance test - gestational diabetes	GTTP	66542
Osmolality, serum or urine	OSML	66563
Ovary - tissue antigens - antibodies	AOV	71109
Oxalate	OXAL	66752
Oxazepam	OXAZ	66812
PAA (phenyl acetic acid)	PAA	66779
Palmitic acid in amniotic fluid	PALM	66749
Pap smear	CCR	73053
Papanicolaou test	CCR	73053
Paracetamol	PARA	66800
Parainfluenza 1 - microbial antibody testing	PF1	69384
Parainfluenza 2 - microbial antibody testing	PF2	69384

Parainfluenza 3 - microbial antibody testing	PF3	69384
Paraprotein characterisation - by electrophoresis, and immunoelectrophoresis or immunofixation or isoelectric focussing	PPRO	71059
Paraprotein quantitation - by electrophoresis	EPPI	71057
Paraprotein characterisation - on concurrently collected serum or urine	PPSU	71060
Paraquat	PARQ	66812
Parasites - microscopic examination of faeces	OCP	69336-42
Parathyroid - tissue antigens - antibodies	PTHA	71109
Parathyroid hormone (PTH)	PTH	66695
Paratyphi - microbial antibody testing	PTY	69384
Partial thromboplastin time	PTT	65120
Patient episode initiation fees	PEI	73901-15
Pentobarbitone	PENT	66812
Perhexiline	PHEX	66812
Pertussis - microbial antibody testing	PER	69384
Phenobarbitone	PHBA	66800
Phensuximide	PHEN	66812
Phenylacetic acid	PAA	66779
Phenytoin	PHEY	66800
Phosphate	PHOS	66500
Phosphatidylglycerol	PTGL	66749
Plasminogen	PLAS	65139
Platelet - tissue antigens - antibodies	APA	71109
Platelet - aggregation	PLTG	65144
Platelet - count	PLTC	65070
PM-Sc1 - tissue antigens - antibodies	PM1	71119
Poliomyelitis - microbial antibody testing	PLO	69384
Porphobilinogen in urine	UPG	66782
Porphyrins - quantitative test, 1 or more fractions	PR	66785
Porphyrins in urine - qualitative test	UPR	66782
Potassium	K	66500
Prealbumin	PALB	66632
Prednisolone	PRED	66812
Pregnancy serology - 1 test	MSP1	69405
Pregnancy serology - 2 tests	MSP2	69408
Pregnancy serology - 3 tests	MSP3	69411
Pregnancy serology - 4 tests	MSP4	69413
Pregnancy testing		73806
Pregnancy testing – HCG detection	HCGP	73527,73529
Pregnancy testing - diagnosis of Down's syndrome and neural tube defect (see tests groups at para PQ.4)	NTDD	66740
Pregnancy testing – HCG quantitation	HCG	73529
Primidone	PRIM	66800
Procainamide	PCAM	66800
Progesterone	PROG	66695
Prolactin	PROL	66695
Propranolol	PPNO	66812
Prostate specific antigen	PSA	66655-66659
Protein C	PROC	65132-36, 65142, 65171
Protein S	PROS	65132-36, 65142, 65171
Protein, quantitation of - alpha fetoprotein	AFP	66650-53, 66740, 66743
Protein, quantitation of - alpha-l-antitrypsin	AAT	66635
Protein, quantitation of - beta-2-microglobulin	BMIC	66629
Protein, quantitation of - caeruloplasmin	CPLS	66632
Protein, quantitation of - C-l esterase inhibitor	CEI	66644
Protein, quantitation of - classes or presence and amount of paraprotein	EPPI	71057-71058

by electrophoresis		
Protein, quantitation of - ferritin (see also Iron studies)	FERR	66593
Protein, quantitation of - for Down's syndrome/neural tube defect testing	NTDD	66740
Protein, quantitation of - haptoglobins	HGLB	66632
Protein, quantitation of - microalbumin	MALB	66560
Protein, total - quantitation of	PROT	66500
Proteus OX 19 - microbial antibody testing	POX	69384
Proteus OXK - microbial antibody testing	POK	69384
Prothrombin gene mutation	PGM	65168, 65174
Prothrombin time	PT	65120
Pyruvate	PVTE	66500
Q fever - microbial antibody testing	QFF	69384
Quinalbarbitone	QUIB	66812
Quinidine	QUIN	66800
Quinine	QNN	66812
Rapid plasma reagin test - microbial antibody testing	RPR	69384
RAST	RAST	71079
Rectum - microscopy & culture of material from	MCGR	69312
Red blood cells - Kleihauer	KLEI	65162
Red cell folate & serum B12	B12F	66602
Red cell folate & serum B12 & serum folate if required	B12F	66602
Red cell folate and serum folate	RCF	66599
Red cell porphyrins - qualitative test	RCP	66782
Referred specimen fee		73921
Renin	REN	66695
Reptilase test	REPT	65120
Respiratory syncytial virus - microbial antibody testing	RSV	69384
Respiratory syncytial virus - microbial antigen testing	RSVN	69364
Reticulin – tissue antigens - antibodies	RCA	71119
Reticulocyte count	RETC	65072
Rheumatoid factor	RF	71106
Rheumatoid factor - quantitation	RFQ	71106
Ross River virus - microbial antibody testing	RRV	69384
RSV (respiratory syncytial virus) - microbial antibody testing	RSV	69384
RSV (respiratory syncytial virus) - microbial antigen testing	RSVN	69364
Rubella – serology	RUB	69384
Salicylate (aspirin)	SALI	66800
Salivary gland - tissue antigens - antibodies	ASG	71109
Salmonella typhi (H) - microbial antibody testing	SAH	69384
Salmonella typhi (O) - microbial antibody testing	SAO	69384
Schistosoma - microbial antibody testing	STO	69384
Scl-70 – tissue antigens - antibodies	SCL	71119
Selenium	SE	66669-70
Semen examination	SEE	73523
Semen examination - for spermatozoa (post vasectomy)	SES	73521
Serology - in pregnancy (see Pregnancy serology)		
Serotonin	5HT	66779
Serum - Bl2	B12	66599
Serum - folate (with Bl2 red cell folate)	B12F	66602
Serum - folate (with Bl2)	B12	66599
Sex hormone binding globulin	SHBG	66695
Skeletal muscle - tissue antigens - antibodies	SLA	71109
Skin - cytology	SMCY	73043
Skin - microscopy & culture of material from	MCSS	69306
Skin – microscopy, culture & Chlamydia of material from	MCSK	69309
Skin basement membrane - tissue antigens - antibodies	SKA	71109
Smooth muscle - tissue antigens - antibodies	SMA	71119
Snake venom	HISS	66623
Sodium	NA	66500
Solid tissue or tissues - chemical assays	ENZS	66683

Solid tissue or tissues - cytology of fine needle aspiration	FNCY	73049
Solid tissue or tissues - cytology of fine needle aspiration by, or in presence of pathologist	FNCP	73051
Somatomedin	SOMA	66695
Sotalol	SALL	66812
Specific IgG or IgE antibodies	RAST	71079
Specimen referred fee		73921
Sperm antibodies	SAB	73525
Sperm antibodies - penetrating ability	SPA	73525
Sputum - cytology (1 specimen)	BFCY	73045
Sputum - cytology (3 specimens)	SPCY	73047
Sputum - for mycobacteria - 1 specimen	AFB1	69324
Sputum - for mycobacteria - 2 specimens	AFB2	69327
Sputum - for mycobacteria - 3 specimens	AFB3	69330
Sputum - microscopy & culture of specimens	MCSP	69318
Stelazine	STEL	66812
Steroid fraction or fractions in urine	USF	66695
Streptococcal serology - anti-DNASE B titre - microbial antibody testing	ADNB	69384
Streptococcal serology - anti-streptolysin O titre - microbial antibody testing	ASOT	69384
Streptococcus - Group B	STB	69364
Streptococcus pneumoniae - CSF antigens	SPN	69364
Streptococcus pneumoniae - microbial antibody testing	PCC	69384
Streptococcus pneumoniae - microbial antigen testing	SPN	69364
Strontium	SR	66672-73
Stypven test	STYP	65120
Sugar water test	SWT	65075
Sulthiame (Ospolot)	SUL	66812
Supplementary testing for Hepatitis C antibodies	HCST	69441
Syphilis serology (see test groups at para PQ.4)	STS	69387
Testosterone	TES	66695
Tetanus - microbial antibody testing	TET	69384
Thalassaemia studies	TS	65078
Theophylline	THEO	66800
Thermoactinomyces vulgaris - microbial antibody testing	THE	69384
Thermopolyspora - microbial antibody testing	TPS	69384
Thiopentone	TOPO	66812
Thioridazine	THIO	66812
Throat - microscopy & culture of material from	MCSW	69303
Thrombin time	TT	65120
Thrombophilia testing – see individual thrombophilia tests		
Thyroglobulin	TGL	66650
Thyroglobulin - tissue antigens - antibodies	ATG	71109
Thyroid function tests (including TSH)	TFT	66719
Thyroid microsome - tissue antigens - antibodies	TMA	71109
Thyroid stimulating hormone (if requested on its own, or as a preliminary test to thyroid function testing)	TSH	66716
Thyroid stimulating hormone (if requested with other hormones referred to in item 66695)	TSH	66722-34
Tissue transglutaminase antibodies	TTG	71163
Tobramicin		66800
Total protein	PROT	66500
Toxocara - microbial antibody testing	TOC	69384
Toxoplasma - microbial antibody testing	TOX	69384
TPHA (Treponema pallidum haemagglutination test) - microbial antibody testing	TPHA	69384
Treponema pallidum haemagglutination test - microbial antibody testing	TPHA	69384
Trichinosis - microbial antibody testing	TOS	69384
Triglycerides	TRIG	66500
Trimipramine	TRIM	66812
Troponin	TROP	66518

Tryptic activity in faeces	TAF	66677
TSH receptor antibody test - tissue antigens - antibodies	TSHA	71109
Tuberculosis	MANT	73811
Tumour markers - CA-125 antigen	C125	66650
Tumour markers - CA-15.3 antigen	CA15	66650
Tumour markers - CA-19.9 antigen	CA19	66650
Tumour markers - carcinoembryonic antigen	CEA	66650
Tumour markers - mammary serum antigen	MSA	66650
Tumour markers - prostate specific antigen	PSA	66656
Tumour markers - prostatic acid phosphatase - 1 or more fractions	ACP	66656
Tumour markers - thyroglobulin	TGL	66650
Typhus, Weil-Felix - microbial antibody testing	TYP	69384
Urate	URAT	66500
Urea	U	66500
Urea, electrolytes, creatinine (see test groups at para PQ.4)	U&E	66515
Urethra - microscopy & culture of material from	MCGR	69312
Urine - acidification test	UAT	66587
Urine - catalase test	UCAT	73805
Urine - cystine (cysteine)	UCYS	66782
Urine - cytology - on 1 specimen	BFCY	73045
Urine - cytology - on 3 specimens	SPCY	73047
Urine - haemoglobin	UHB	66782
Urine - microscopy, culture, identification & sensitivity	UMCS	69333
Urine - porphobilinogen	UPG	66782
Urine - porphyrins - qualitative test	UPR	66782
Urine - steroid fraction or fractions	USF	66695
Urine - urobilinogen	UUB	66782
Vagina - microscopy & culture of material from	MCGR	69312
Vagina - cytology on specimens from	CVO	73057
Valproate (Epilim)	VALP	66800
Vancomycin	VAN	66800
Varicella zoster - microbial antibody testing	VCZ	69384
Varicella zoster - microbial antigen testing	VCZN	69364
Vasoactive intestinal peptide	VIP	66695
Vasopressin	ADH	66695
VDRL (Venereal Disease Research Laboratory) - microbial antibody testing	VDRL	69384
Viscosity of blood or plasma	VISC	65060
Vitamins - B12	B12	66599
Vitamins - D	VITD	66608
Vitamins - folate	RCF	66599
Vitamins - quantitation of A, B1, B2, B3, B6, C or E	VIT	66605
VMA (see HMMA)		
Von Willebrand's factor	VWF	65150
Von Willebrand's factor antigen	VWA	65150
Warfarin	WFR	66812
Yersinia enterocolitica - microbial antibody testing	YER	69384
Zinc	ZN	66667-70

PART FIVE - COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

Specimen Type	Complexity Level
Adrenal resection, neoplasm	5
Adrenal resection, not neoplasm	4
Anus, all specimens not otherwise specified	3
Anus, neoplasm, biopsy	4
Anus, neoplasm, radical resection	6
Appendix	3
Artery, all specimens not otherwise specified	3
Artery, biopsy	4
Bartholin's gland - cyst	3
Bile duct, resection - all specimens	6
Bone, biopsy, curettings or fragments - lesion	5
Bone, biopsy or curettings quantitation - metabolic disease	6
Bone, femoral head	4
Bone, resection, neoplasm - all sites and types	6
Bone marrow, biopsy	4
Bone - all specimens not otherwise specified	4
Brain neoplasm, resection - cerebello-pontine angle	4
Brain or meninges, biopsy - all lesions	5
Brain or meninges, not neoplasm - temporal lobe	6
Brain or meninges, resection - neoplasm (intracranial)	5
Brain or meninges, resection - not neoplasm	4
Branchial cleft, cyst	4
Breast, excision biopsy, guidewire localisation - non-palpable lesion	6
Breast, excision biopsy, or radical resection, malignant neoplasm or atypical proliferative disease - all specimen types	6
Breast, incision biopsy or needle biopsy, malignant neoplasm - all specimen types	4
Breast – microdochectomy	6
Breast tissue - all specimens not otherwise specified	4
Bronchus, biopsy	4
Carotid body - neoplasm	5
Cholesteatoma	3
Digits, amputation - not traumatic	4
Digits, amputation - traumatic	2
Ear, middle and inner - not cholesteatoma	4
Endocrine neoplasm - not otherwise specified	5
Extremity, amputation or disarticulation - neoplasm	6
Extremity, amputation - not otherwise specified	4
Eye, conjunctiva - biopsy or pterygium	3
Eye, cornea	4
Eye, enucleation or exenteration - all lesions	6
Eye - not otherwise specified	4
Fallopian tube, biopsy	4
Fallopian tube, ectopic pregnancy	4
Fallopian tube, sterilization	2
Fetus with dissection	6
Foreskin - new born	2
Foreskin - not new born	3
Gallbladder	3
Gallbladder and porta hepatis-radical resection	6
Ganglion cyst, all sites	3
Gum or oral mucosa, biopsy	4

Heart valve	4
Heart - not otherwise specified	5
Hernia sac	2
Hydrocele sac	2
Jaw, upper or lower, including bone, radical resection for neoplasm	6
Joint and periarticular tissue, without bone - all specimens	3
Joint tissue, including bone - all specimens	4
Kidney, biopsy including transplant	5
Kidney, nephrectomy transplant	5
Kidney, partial or total nephrectomy or nephroureterectomy - neoplasm	6
Kidney, partial or total nephrectomy - not neoplasm	4
Large bowel (including rectum), biopsy - all sites	4
Large bowel, colostomy - stoma	3
Large bowel (including rectum), biopsy, for confirmation or exclusion of Hirschsprung's Disease	5
Large bowel (including rectum), polyp	4
Large bowel, segmental resection - colon, not neoplasm	5
Large bowel (including rectum), segmental resection, neoplasm	6
Larynx, biopsy	4
Larynx, partial or total resection	5
Larynx, resection with nodes or pharynx or both	6
Lip, biopsy - all specimens not otherwise specified	3
Lip, wedge resection or local excision with orientation	4
Liver, hydatid cyst or resection for trauma	4
Liver, total or subtotal hepatectomy - neoplasm	6
Liver - all specimens not otherwise specified	5
Lung, needle or transbronchial biopsy	4
Lung, resection - neoplasm	6
Lung, wedge biopsy	5
Lung segment, lobar or total resection	6
Lymph node, biopsy - all sites	4
Lymph node, biopsy – for lymphoma or lymphoproliferative disorder	5
Lymph nodes, regional resection - all sites	5
Mediastinum mass	5
Muscle, biopsy	6
Nasopharynx or oropharynx, biopsy	4
Nerve, biopsy neuropathy	5
Nerve, neurectomy or removal of neoplasm	4
Nerve - not otherwise specified	3
Nose, mucosal biopsy	4
Nose or sinuses, polyps	3
Odontogenic neoplasm	5
Odontogenic or dental cyst	4
Oesophagus, biopsy	4
Oesophagus, diverticulum	3
Oesophagus, partial or total resection	6
Omentum, biopsy	4
Ovary with or without tube - neoplasm	5
Ovary with or without tube - not neoplasm	4
Pancreas, biopsy	5
Pancreas, cyst	4
Pancreas, subtotal or total with or without splenectomy	6
Parathyroid gland(s)	4
Penisectomy with node dissection	5
Penisectomy - simple	4
Peritoneum, biopsy	4
Pituitary neoplasm	4

Placenta - not third trimester	4
Placenta - third trimester, abnormal pregnancy or delivery	4
Pleura or pericardium, biopsy or tissue	4
Products of conception, spontaneous or missed abortion	4
Products of conception, termination of pregnancy	3
Prostate, radical resection	6
Prostate - all types of specimen not otherwise specified	4
Retroperitoneum, neoplasm	5
Salivary gland, Mucocele	3
Salivary gland, neoplasm - all sites	5
Salivary gland - all specimens not otherwise specified	4
Sinus, paranasal, biopsy	4
Sinus, paranasal, resection - neoplasm	6
Skin, biopsy - blistering skin diseases	4
Skin, biopsy - for investigation of alopecia, other than for male pattern baldness, where serial horizontal sections are taken	5
Skin, biopsy - for investigation of lymphoproliferative disorder	5
Skin, biopsy - inflammatory dermatosis	4
Skin,eyelid, wedge resection	4
Skin, local resection - orientation	4
Skin, resection of malignant melanoma or melanoma in-situ	5
Skin - all specimens not otherwise specified including all neoplasms and cysts	3
Small bowel - biopsy, all sites	4
Small bowel, diverticulum	3
Small bowel, resection - neoplasm	6
Small bowel – resection, all specimens	5
Soft tissue, infiltrative lesion, extensive resections at least 5cm in maximal dimension	6
Soft tissue, lipoma and variants	3
Soft tissue, neoplasm, not lipoma - all specimens	5
Soft tissue - not otherwise specified	4
Spleen	5
Stomach, endoscopic biopsy or endoscopic polypectomy	4
Stomach, resection, neoplasm - all specimens	6
Stomach - all specimens not otherwise specified	4
Tendon or tendon sheath, giant cell neoplasm	4
Tendon or tendon sheath - not otherwise specified	3
Testis, biopsy	5
Testis and adjacent structures, castration	2
Testis and adjacent structures, neoplasm with or without nodes	5
Testis and adjacent structures, vas deferens sterilization	2
Testis and adjacent structures - not otherwise specified	3
Thymus - not otherwise specified	5
Thyroglossal duct - all lesions	4
Thyroid - all specimens	5
Tissue or organ not otherwise specified, abscess	3
Tissue or organ not otherwise specified, haematoma	3
Tissue or organ not otherwise specified, malignant neoplasm with regional nodes	6
Tissue or organ not otherwise specified, neoplasm local	4
Tissue or organ not otherwise specified, pilonidal cyst or sinus	3
Tissue or organ not otherwise specified, thrombus or embolus	3
Tissue or organ not otherwise specified, veins varicosity	3
Tissue or organ - all specimens not otherwise specified	3
Tongue, biopsy	4
Tongue or tonsil, neoplasm local	5
Tongue or tonsil, neoplasm with nodes	6
Tonsil, biopsy - excluding resection of whole organ	4

Tonsil or adenoids or both	2
Trachea, biopsy	4
Ureter, biopsy	4
Ureter, resection	5
Urethra, biopsy	4
Urethra, resection	5
Urinary bladder, partial or total with or without prostatectomy	6
Urinary bladder, transurethral resection of neoplasm	5
Urinary bladder - all specimens not otherwise specified	4
Uterus, cervix, curettings or biopsy	4
Uterus, cervix cone, biopsy (including LLETZ or LEEP biopsy)	5
Uterus, endocervix, polyp	3
Uterus, endometrium, polyp	3
Uterus with or without adnexa, malignant neoplasm - all specimen types not otherwise specified	6
Uterus with or without adnexa, neoplasm, Wertheim's or pelvic clearance	6
Uterus and/or cervix - all specimens not otherwise specified	4
Vagina, biopsy	4
Vagina, radical resection	6
Vaginal mucosa, incidental	3
Vulva or labia, biopsy	4
Vulval, subtotal or total with or without nodes	6