

**Australian Government
Department of Health and Ageing**

Medicare Benefits Schedule Book

Operating from 1 November 2006

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.

**The latest Medicare Benefits Schedule information
is available from *MBS Online*
at <http://www.health.gov.au/mbsonline>**

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)**
 - **Miscellaneous Services - 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)
- . **Miscellaneous Services – further Allied Health initiatives (Category 8) – (ochre edging)**

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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)**
 - **Allied Health and Dental Care Services** (Category 8) – **(ochre edging)**
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Schedules of Services

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

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

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

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

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

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

Structure of Schedule of Services

The book has been structured to group professional services according to their general nature, while some have been further organised into sub-groups according to the particular nature of the services concerned. For example, Group T8 covering surgical operations has been divided into 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 – 02 9895 3346	WA - 08 9214 8488
VIC - 03 9605 7964	TAS - 03 6215 5740
QLD - 07 3004 5450	ACT - 02 6124 6362
SA - 08 8274 9788	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

1 Oxford Street
DARLINGHURST NSW 2010
Tel (02) 9263 3555

VICTORIA

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

QUEENSLAND

Samuel Griffith Place
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/mbsonline. 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.

General Fee Increase

The following changes to Medicare schedule fees will apply from 1 November 2006:

- A 2.1% 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 2.1% increase will apply to all other items except Diagnostic Imaging and Pathology items; and
- a 1% increase applies to items in Group I4 in the Diagnostic Imaging category of this book.

Increase in Maximum Gap Payment

The maximum patient gap between the Schedule fee and the benefits payable for out-of-hospital services increases to \$63.90 as at 1 November 2006. The 85% benefit level will apply for all fees up to \$426.00, after which, benefits are calculated at the Schedule fee less \$63.90.

REVIEW OF GENERAL MEDICAL SERVICES

- **Mental Health** - New MBS items have been introduced as part of the COAG Mental Health *Better Access to Psychiatrists, Psychologists, and General Practitioners through the Medicare Benefits Scheme* initiative, for services provided to patients with a mental disorder. These include services provided by psychiatrists, GPs, psychologists and other allied mental health providers:
 - New psychiatrist items 296, 297, and 299 for new patients, and an increase in rebate levels for psychiatrist items 291, 293, 304, 306, 314, 316, 319, 324, 326, 334, and 336;
 - New GP items for preparation of a GP Mental Health Care Plan (2710), for review of a GP Mental Health Care Plan (2712), and for a GP Mental Health Care Consultation (2713); and minor consequential changes to referral arrangements and an increase in rebates for Focused Psychological Strategies services provided by GPs (items 2721 and 2725);
 - New Psychological Therapy items (80000 to 80020) for up to 12 individual and up to 12 group consultations per patient with eligible clinical psychologists in a calendar year - note M6 explains the circumstances under which these items can be claimed.
- **Public health physician attendances** - Fees for items 410 to 413 have been increased to align rebates with services provided by vocationally recognised general practitioners.
- **Sports physician attendances** - Fees for items 444 to 449 have been increased to align rebates with services provided by vocationally recognised general practitioners.
- **Australian Better Health Initiative: A joint Australian, State and Territory government initiative**
The following items have been introduced as part of the Australian Better Health Initiative package agreed by the Council of Australian Governments (COAG):
 - **45 Year Old Health Check** - Item 717 provides a rebate for general practitioners to undertake a health check for a patient between 45 and 49 years of age (inclusive) who is at risk of developing a chronic disease. The aim of the health check is to assist with detection and prevention of chronic disease and enable early intervention strategies to be put in place where appropriate.
 - **Cancer Care Case Conferences** - Items 871 and 872 provide rebates for doctors to participate in or lead a cancer care case conference. They are designed to assist a multidisciplinary team approach to the diagnosis and management of cancer and the development of treatment and care plans.
- **Asthma Cycle of Care** - The Asthma 3+ Visit Plan has been renamed the Asthma Cycle of Care (see items 2546-2559 and 2664-2677) and the requirements for the incentive payments have changed. Items 2546 and 2664 and Note A.30 explain the new requirements.
- **Diabetes Cycle of Care** - Note A.29 and Items 2517 and 2620 have been amended to require eye and feet examinations only if relevant.
- **Pain Medicine** - The Minister for Health and Ageing has agreed to change the requirements for access to the pain medicine attendance and case conference items. All recognised specialists and consultant physicians in the specialty of pain medicine can access items 2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000.
- **Palliative Medicine** - The Minister for Health and Ageing has agreed to change the requirements for access to the palliative medicine attendance and case conference items. All recognised specialists and consultant physicians in the specialty of palliative medicine can access items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093.

- **Pregnancy Support Counselling** - Item 4001 has been introduced for the provision of non-directive pregnancy support counselling services by eligible medical practitioners (including GPs, but not including specialists and consultant physicians). A new note, A.43 explains the circumstances under which the item can be claimed.
- **Outer Metropolitan Specialist Trainees** – A new group of items have been created for specialist trainees undertaking training under the Outer Metropolitan Specialist Trainee Program. The new Group A25 comprises attendance only items mirroring existing Levels A, B, C and D of Group A1 surgery attendance items 3, 23, 36 and 44.
 - A new item 5906 has been introduced for a professional attendance by an outer metropolitan specialist trainee for an obvious problem characterised by the straightforward nature of the task requiring limited examination and management.
 - A new item 5908 has been introduced for a professional attendance by an outer metropolitan specialist trainee involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems.
 - A new item 5910 has been introduced for a Professional attendance by an outer metropolitan specialist trainee 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.
 - A new item 5912 has been introduced for a professional attendance by an outer metropolitan specialist trainee 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.
- **Neurosurgery consultation structure** - a time based consultation structure has been introduced for consultations provided by neurosurgeons. The new structure includes an initial specialist referred consultation (Item 6009) and a range of subsequent time based consultations denoting increasing levels of complexity, which may apply in a single course of treatment.
- **Services provided by a Practice Nurse** - Items 10994 and 10995 have been introduced for Pap smears and preventive checks provided by practice nurses on behalf of GPs. Items 10998 and 10999 have been amended and can now be claimed in urban as well as rural areas.
- **Implantable Cardioverter Defibrillator testing** – Item 11727 has been introduced to cover the testing of an Implantable Cardioverter Defibrillator.
- **Carbon-labelled Urea Breath Test**- Following a recommendation of the Medical Services Advisory Committee, item 12533 has been amended to become a first line procedure for the diagnosis of Helicobacter pylori infection.
- **Implantable Drug Delivery System for the treatment of severe chronic spasticity** – Item 14233 has been amended to correct an error. Item 14233 can only be claimed when baclofen is used, which was the intention of the item.
- **Infliximab** - A new item (14245) has been introduced for the infusion of infliximab. This item should be used in accordance with the Section 100 restrictions.
- **Antenatal check provided by a midwife, nurse or registered Aboriginal Health Worker on behalf of a medical practitioner** - Item 16400 has been introduced to provide rebates for antenatal care performed by eligible health professionals when provided in rural and remote areas on behalf of a GP or specialist.
- **Anaesthesia consultation structure:** a time based consultation structure specific to anaesthesia has been introduced to better reflect current clinical practice by providing for those pre-anaesthesia attendances that are longer and more complex and accommodating the range of services anaesthetists provide.
- **Botulinum toxin items**
 - Two new items (18372 and 18373) have been introduced to provide for the increased complexity involved in the treatment of bilateral blepharospasm using botulinum toxin.
 - A minor change was made to item 18370 to better define the original intent of the item.
- **General Surgery** - A new explanatory note has been introduced to clarify that the aftercare period for item 30071 is 2 days rather than the standard aftercare periods of 10 days for skin excisions. Item 30178 has been renumbered to 45569 and moved to Plastics and Reconstructive Surgery Subgroup.
- **Synacthen Stimulation Testing** - The Pathology Services Table Committee reviewed the procedures related to the former item 66689 and recommended that the procedure should only be performed by a doctor or pathologist trained in resuscitation and performed in a facility with life support procedures. The new item descriptor (Item 30097) will be included in the Group T8 - Surgical Operations - Subgroup 1 - General.
- **Vertebroplasty** - Items 35400 and 35402 have been amended to include an 85% benefit, backdated to the date of introduction of the item, 1 November 2005.
- **Uterine Artery Embolisation** - Following a recommendation of the Medical Services Advisory Committee (MSAC), interim item 35410 has been introduced for this procedure on specialist gynaecological referral. Medicare coverage is available for five years until November 2011, before which time MSAC will review the results of trials conducted in the intervening period.
- **Endovascular Coiling of Intracranial Aneurysms** – Following a recommendation of the Medical Services Advisory Committee (MSAC), item 35412 has been introduced for the treatment of intracranial aneurysms, ruptured or unruptured, by endovascular occlusion with detachable coils.
- **Cystoscopy** – Item 36845 has been amended so that the 85% benefit can now be claimed.

- **High Dose Rate Brachytherapy** - New item 37227 has been introduced to cover the insertion of catheters into the prostate as part of the High Dose Rate Brachytherapy procedure. It is intended that the removal of the catheters following completion of the Brachytherapy is also covered under this item.
- **Coronary Pressure Wire** - Following a recommendation of the Medical Services Advisory Committee, item 38241 has been introduced for use of this procedure to measure fractional flow reserve (FFR) and coronary flow reserve (CFR) in one or more intermediate coronary artery or graft lesion in patients where previous stress testing has either not been performed or the results are inconclusive.
- **Cardio-Thoracic** - Item 38306 has been amended to clarify that the item should only be claimed once per occlusional site. A note for guidance relating to this item has also been included.
 - Item 38568 has been amended to clarify that the procedure may be performed by open exposure, minimally invasive surgery, percutaneous or endovascular means.
 - The inclusion of new explanatory notes for items 38470-38766 to clarify that these procedures must be performed by open exposure or minimally invasive means.
 - The inclusion of new header descriptors in the cardio-thoracic subgroup applying to items 38470 – 38766 to clarify that the items must be performed by open exposure or minimally invasive means.
- **Cardiac Resynchronisation Therapy** - Following a recommendation of the Medical Services Advisory Committee, item 38371 has been introduced for use of a CRT device capable of defibrillation in patients who have moderate to severe chronic heart failure, are in sinus rhythm and have a left ventricular ejection fraction of less than or equal to 35% and a QRS duration greater than or equal to 120ms.
- **Implantable Cardioverter Defibrillator** - Following a recommendation of the Medical Services Advisory Committee, items 38384 and 38387 have been introduced for use of this procedure for primary prevention of sudden cardiac death in patients with a left ventricular ejection fraction of less than or equal to 30%, or who have chronic heart failure with mild to moderate symptoms and a left ventricular ejection fraction less than or equal to 35%.
- **Neurosurgical** – Item 39327 has been amended allow for the removal of a tumour from the cranial nerve under this item and to clarify that this items can not be claimed in association with items 41575, 41576, 41578 or 41579.
- **Ear, Nose and Throat** - Item 41764 has been amended to clarify that the item is to cover both unilateral and bilateral procedures.
- **Ophthalmology**
 - Minor amendments have been made to the descriptors for items 42785 to 42789 and 42740 to better define their intent.
 - An explanatory note (T8.79) has been introduced to define what an imbedded foreign body is for the purposes of item 42644.
 - Items 42833 to 42842 and 42848 to 42851 have been changed to reflect that squint operations are more complex in patients 14 years and under, who have had previous squint, retinal or extra ocular operations on the eye or eyes, or who have concurrent thyroid eye disease.
 - Explanatory note T8.89 has been amended to better define the original intent of item 42845.
 - Item 15351 has been amended and two new items (42801 and 42802) have been introduced to provide for construction, insertion and removal of radioactive plaques for the treatment of choroidal melanomas.
 - Item 42578 has been deleted as the service described is covered by items 42581 and 42590.
- **Plastic and Reconstructive Surgery**
 - New items have been introduced for H-flap and double advancement flaps (item 45207), revision of direct, indirect or local flaps by liposuction (item 45240), breast prosthesis replacement where no excision of tissue is required (item 45553) treatment of tuberous, tubular or constricted breast subject to approval of the Medicare Claims Review Panel (item 45559) and closure of abdomen with musculoaponeurotic repair (item 45570).
 - Items 45200-45206 have been amended to exclude the claiming of H-flaps or double advancement flaps under this item.
 - Item 45239 has been amended to provide for revision of direct, indirect or local flaps by direct incision or suture.
 - Items 45497-45499 have been amended to allow for the use of pedicle flaps under these items.
 - A new explanatory note for skin flap has been included to clarify that flaps are only payable when clinically appropriate. A definition of clinically appropriate is also included.
 - Item 45522 has been amended to exclude the treatment of gynaecomastia. A note for guidance has also been included for this item.
 - Item 45530 has been amended to clarify that items 30165, 30168, 30171, 30174 and 30177 should not be claimed in association with this item. A note for guidance has also been included for this item.
 - Items 45551 and 45552 have been amended to remove the word 'complete' as in certain circumstances a full capsulectomy cannot be performed.
 - Item 45554 has been amended to clarify that the item is to cover both the removal and the replacement of the prosthesis.
 - A new explanatory note for breast prosthesis (items 45552-45555) items to clarify that that Medicare benefits are only payable when the replacement prosthesis is the same size as the prosthesis removed.
 - Item 45585 has been amended to include treatment of macrodystrophia lipomatosa. A note for guidance has also been included for this item.
 - Item 46330 has been amended to clarify that the procedure can be done with or without an arthrotomy.

- Item 46375 has been amended to have the 85% benefit reinstated.
- **Orthopaedics**
 - Items referring to discectomy, laminectomy and meniscectomy have been amended to reflect that the procedure may be partial or total.
 - Items 49539 and 49542 for reconstructive surgery have been amended to clarify that benefits are payable for surgery involving one or both cruciate ligaments.
 - New items (49116, 49117, 49210, 49211, 49716 and 49717) have been introduced to provide for joint revision services for the elbow, wrist and ankle.

A number of new items, and amendments to current items, have been introduced to provide separate items for paediatric orthopaedic surgery. These changes include:

 - 12 new conjoint surgery items (50450-50476) have been introduced to provide for single event multilevel surgery in paediatric patients with hemiplegic and diplegic cerebral palsy.
 - One new item (49728) has been introduced to provide for lengthening of the gastrocnemius aponeurosis for treatment of equinus deformity.
 - 23 new items (50500-50588) have been introduced to provide for treatment of fractures requiring reduction in paediatric patients.
 - Minor changes are reflected in fracture items 47405 and 47408 to confirm their intent.
 - 12 new items (50600-50644) have been introduced to provide for spine surgery for scoliosis and kyphosis in paediatric patients.
 - Item 48609 has been deleted as the service described is no longer used in current clinical practice.
 - 3 new items (50650-50658) have been introduced to provide for the treatment of hip dysplasia and dislocation in paediatric patients.
 - An administrative block has been removed from item 50353 to allow for the item to be claimed when reapplication of a hip spica is required.
- **Artificial Intervertebral Disc Replacement** - Following a recommendation of the Medical Services Advisory Committee (MSAC), interim items 48691-93 have been introduced for single-level lumbar total disc replacement in patients with single-level intralumbar disc disease, in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level, who have failed conservative therapy. Medicare funding for these items is available for three years until November 2009, before which time MSAC will review the results of trials conducted in the intervening period. Items 48660, 48669 and 48684 have been amended to clarify that they do not cover artificial intervertebral total disc replacement.

CHANGES TO DIAGNOSTIC IMAGING SERVICES

- Following a recommendation by the Obstetric and Gynaecological Ultrasound Management Committee, item 55728 has been removed from the table of items due to low usage.
- Following a recommendation by the Nuclear Imaging Consultative and Economics Committee, the schedule fees for items 61302 to 61650 have been increased by 1%.
- An indexation increase of 2.1% has been applied to bulk billed items 64990 and 64991.
- Following a recommendation by the Cardiac Imaging Management Committee the fee for echocardiography items 55113, 55114 and 55115 has been decreased by 2%. The fee decrease was effective from 1 September 2006.

CHANGES TO PATHOLOGY SERVICES

PA.2.2 Services Where Request Not Required

PA.2.2 (ii) (c) has been amended to accommodate the introduction of a new pathologist determinable antigen detection item (69367) for 3 or more tests which accompanies the existing items (69364 and 69365). Item 69365 has been amended to allow for 2 tests only.

PA.2.2 (ii) (d) has been created to accommodate the making of the existing item 73220 - HLA-B27 typing by nucleic acid amplification (NAA) as a pathologist determinable item where the results of 71147 may be unsatisfactory and NAA confirmation would be useful.

PP.14 has been created to note the transfer of existing items from Group P1 (Haematology) items 65168, 65174, 65200 and item 66794 from Group P2 to Group P7 (Genetics) as items 73308, 73311, 73314, 73317 and the introduction of the new item in Group P7 (Genetics) item 73320 HLA-B27 typing by nucleic acid amplification (NAA) which was effective as of 1 May 2006.

Group P3 – Microbiology – Antigen Detection

There has been an amendment to the descriptor for Item 69365 to reduce the number of allowable tests to 2, in light of the introduction of the new item 69367 which provides for 3 or more tests as described in item 69364.

Group P7 – Genetics

There has been an amendment to the descriptor for Item 73220 to state that the detection of HLA-B27 by nucleic acid amplification includes a service described in 71147 unless the service in item 73320 is rendered as a pathologist determinable service, and that the item is subject to rule 27.

PX.1 Rules for the Interpretation of the Pathology Services Table

Services to which rule 3 does not apply

4. (2) Rule 3 does not apply to any of the following pathology services:
Dot point (h) has been amended to remove the reference to potassium.

Antigen detection – Group P3 (microbiology)

Rule 26 has been amended to describe the requirements for pathologist determinable services provided under the new item 69367.

HLA-B27 testing – Group P7 (Genetics)

Rule 27 has been created to outline the requirements for the use of item 73220 as a pathologist determinable item.

ALLIED HEALTH AND DENTAL SERVICES

New Focussed Psychological Strategies items (80100 to 80170) that provide patients with up to 12 individual and 12 group consultations with eligible psychologists, occupational therapists and social workers in a calendar year - note M7 explains the circumstances under which these items can be claimed.

Pregnancy Support Counselling - Items 81000-81010 inclusive have been introduced for the provision of non-directive pregnancy support counselling services by eligible psychologists, social workers and mental health nurses. A new note, M.8 explains the circumstances under which these items can be claimed

SUMMARY OF CHANGES

The 1 November 2006 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following symbols appearing above the item number:-

(a)	new item	†
(b)	amended description	‡
(c)	fee amended	+
(d)	item number change	*

New Items

296	297	299	717	871	872	2710	2712	2713	4001	5906
5908	5910	5912	6007	6009	6011	6013	6015	10994	10995	11727
14245	16400	17610	17615	17620	17625	17640	17645	17650	17655	17680
17690	18372	18373	30097	35410	35412	37227	38241	38371	38384	38387
40850	40851	40852	40854	40856	40858	40860	40862	41603	41604	42801
42802	45207	45240	45553	45559	45570	48691	48692	48693	49116	49117
49210	49211	49716	49717	49728	50450	50451	50455	50456	50460	50461
50465	50466	50470	50471	50475	50476	50500	50504	50508	50512	50516
50520	50524	50528	50532	50536	50540	50544	50548	50552	50556	50560
50564	50568	50572	50576	50580	50584	50588	50600	50604	50608	50612
50616	50620	50624	50628	50632	50636	50640	50644	50650	50654	50658
69367	80000	80005	80010	80015	80020	80100	80105	80110	80115	80120
80125	80130	80135	80140	80145	80150	80155	80160	80165	80170	81000
81005	81010									

Deleted Items

17603	42578	48609	55728
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Amended Description

300	302	304	306	308	310	312	314	316	318	319
721	723	729	731	2497	2501	2503	2504	2506	2507	2509
2517	2518	2521	2522	2525	2526	2546	2547	2552	2553	2558
2559	2598	2600	2603	2606	2610	2613	2616	2620	2622	2624
2631	2633	2635	2664	2666	2668	2673	2675	2677	2721	10998
10999	12533	14233	15351	18366	18368	18370	35400	35402	38306	38390
38393	38568	39124	39139	39327	40300	40301	40303	40306	40309	40312
40318	40324	40327	40330	40333	40342	41764	42740	42785	42786	42788
42789	42833	42836	42839	42842	42848	42851	45200	45203	45206	45239
45497	45498	45499	45522	45530	45551	45552	45554	45569	45585	45755
45794	45797	45869	46330	47405	47408	48636	48654	48657	48660	48669
48684	49503	49506	49539	49542	49560	49561	49562	51300	51303	51800
51803	55768	55770	55772	55774	69365	73320				

Fee Amended

291	293	304	306	314	316	319	324	326	334	336
410	411	412	413	444	445	446	447	448	449	2721
2725										

Item Number Change

Old	New
30178	45569

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 2006 and continues beyond that date, the general rule is that the 1 November 2005 level of fees and benefits would apply.

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 \$63.90 (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 or registered Aboriginal Health Worker 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 \$345.50 (indexed annually from 1 January). Thereafter, patients are reimbursed 100% of the Schedule fee. This is known as the original Medicare safety net. Under the extended Medicare 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 Medicare-claimable services, once annual thresholds are reached. For families in receipt of the Family Tax Benefit Part A and concession card holders, the threshold is \$500 (indexed annually from 1 January) and for all other individuals and families, the threshold is \$1,000 (indexed annually from 1 January). A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25. 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.

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. EFT payments may be requested by completing the requested details on the provider number application form.

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 approved general practice 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; or
 - the practitioner is associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, After Hours OMPs program, Rural OMPs program or Outer Metropolitan OMPs program.
- 2.3.2 Locums can direct Medicare payments to the principal of the practice by either arranging a pay group link and/or by nominating the principal as the payee on bulk bill stationery. Alternatively, EFT payments can be arranged by completing the requested details on the provider number application form.

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 calling Medicare Australia on 132 150.

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

The Colonial State Bank Tower
130 George Street
PARRAMATTA NSW 2165

VICTORIA

State Headquarters
460 Bourke Street
MELBOURNE VIC 3000

QUEENSLAND

State Headquarters
444 Queen Street
BRISBANE QLD 4000

SOUTH AUSTRALIA

State Headquarters
209 Greenhill Road
EASTWOOD SA 5063

WESTERN AUSTRALIA

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

TASMANIA

242 Liverpool Street
HOBART TAS 7000

AUSTRALIAN CAPITAL TERRITORY

134 Reed Street
TUGGERANONG ACT 2901

NORTHERN TERRITORY

As per South Australia

3. PATIENT ELIGIBILITY FOR MEDICARE

3.1 Eligible Persons

3.1.1 An "eligible person" is a person who resides permanently in Australia. This includes New Zealand citizens 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 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 to persons who have applied for permanent residence.

3.2.3 Medicare cards with the words "RECIPROCAL HEALTH CARE" 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 Australia has Reciprocal Health Care Agreements with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Norway, Italy and Malta.

3.5.2 The Agreements provide 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. These visitors receive services by presenting their passports. They are not issued with Medicare cards.

3.5.4 Visitors are eligible for the duration of their stay, except in the case of Italy and Malta, where benefits are for six months only.

3.5.5 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 covered under the Agreements.

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 seeking recognition as a Fellow of the RACGP should apply to the Manager, Health Programs Branch, Medicare Australia, at any of the addresses listed in paragraph 2.9.

A General Practice (GP) Trainee should apply to General Practice Education and Training Limited (GPET) for a general practice trainee placement. GPET will advise Medicare Australia when a placement is approved. GP Trainees need to apply for a provider number using the appropriate provider number application form available on Medicare Australia's website.

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 GPREC/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 GPREC/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 undertaken a professional attendance with the patient and 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.

6.3 Examination by Specialist Anaesthetists

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

6.4 Who can Refer

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

6.4.2 Referrals are to be made as follows:-

- (a) to a recognised consultant physician -
 - (i) by another medical practitioner; or
 - (ii) by an approved dental practitioner¹ (oral surgeon), where the referral arises out of a dental service;
- (b) to a recognised specialist -
 - (i) by another medical practitioner; or
 - (ii) by a registered dental practitioner², where the referral arises out of a dental service; or
 - (iii) by a registered optometrist where the specialist is an ophthalmologist.

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 deposit 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 Australia. 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 DB1N, DB1H)

7.8.1 Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. 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 DB1N 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 (Forms DB6Ba & DB6Bb)

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

- Form DB6Ba. This form is used to order larger stocks of forms DB3, DB4 and DB5 (and where a practitioner uses these forms, DB1N and DB1H), kits for optical scanning stationery (which comprises DB2's (GP, OP and OT)), DB1's pre addressed envelopes and an instruction sheet for the use of direct-bill scanning stationery.
- Form DB6Bb. This form is used to order stocks of forms and additional products (including Medicare Safety Net forms and promotional material). These forms are available from Medicare.

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 PRACTITIONERS, INDIVIDUAL CLAIMS AND SCHEDULE SERVICES

Health Practitioners

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 person, such as a health practitioner, to determine whether the person has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing or dispensing 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. It is also an offence under Section 82 for a person or an officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

8.1.3 Medicare Australia monitors health practitioners' claiming patterns. Where an anomaly is detected, 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 (Professional Services Review) Regulations 1999*, is 80 or more professional attendances on each of 20 or more days in a 12-month period.
- A professional attendance means a service of a kind mentioned in group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A16, A17, A18, A19, A20, A21, A22 or A23 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 Medicare benefit arrangements for up to three years.

8.1.16 The revised PSR arrangements apply in relation to requests by Medicare Australia 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 Medicare Participation Review Committees determine what administrative action should be taken against a practitioner who has been successfully prosecuted for various relevant offences, has breached an Approved Pathology Practitioner undertaking; has engaged in prohibited diagnostic imaging practices; or has two (or more) Final Determinations of inappropriate practice under the Professional Services Review Scheme.

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 Medicare benefit arrangements for up to five years.

8.2.3 In addition, Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973*. (Section 19B of the *Health Insurance Act 1973* provides details of the circumstances in which a Medicare benefit is not payable in respect of services rendered by disqualified practitioners).

8.3 Referral of professional issues to regulatory and other bodies

8.3.1 Provision is made under the *Health Insurance Act 1973* for the referral, to an appropriate regulatory body, of any significant threat to the life or health of any person that the conduct of the person under review has caused, is causing, or is likely to cause.

8.3.2 Referrals of practitioners are made to the appropriate registering, licensing or practice regulating bodies in the State or Territory that the practitioner practises in. For instance, in the case of medical practitioners, this will be the State or Territory medical board.

8.3.3 Similar powers are also provided for the referral of persons who are not practitioners to the appropriate registering, licensing or practice regulating bodies.

8.3.4 In addition, provision is made for the referral of a statement of concerns, to an appropriate regulatory body, of any non-compliance by a practitioner with professional standards. The regulations specify the appropriate bodies to receive the referrals.

Schedule Services

8.4 Medicare Benefits Consultative Committee (MBCC)

8.4.1 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.

8.4.2 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.

8.5 Medical Services Advisory Committee (MSAC)

8.5.1 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.

8.5.2 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.

8.5.3 The assessment of evidence is 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 activity strengthens and consolidates evidence based assessment under the umbrella of MSAC and complements the functions and activities of the Medicare Benefits Consultative Committee, Pathology Services Table Committee and the Management Committees for the four Memoranda of Understanding in Diagnostic Imaging.

8.5.4 Since its establishment MSAC has developed 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 can be found at its internet site www.health.gov.au/msac/index.htm

8.5.5 Contact with MSAC can be made via email on msac.secretariat@health.gov.au or by phoning the MSAC secretariat on (02) 6289 6811.

8.6 Pathology Services Table Committee (PSTC)

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

8.6.2 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.

8.7 Review of Claims Requiring Prior Approval for Payment of Benefits

8.7.1 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, 45559, 45585, 45586, 45588, 45639, 50125.

8.7.2 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.

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

8.7.4 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 or registered Aboriginal Health Worker 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 \$63.90 (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 \$345.50 (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 seborrheic 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 -	02 9895 3346
VIC -	03 9605 7964
QLD -	07 3004 5280
SA -	08 8274 9788
NT -	08 8274 9788
WA -	08 9214 8488
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 16400 and 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.

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 for the purposes of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used in the therapy.

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: medical practitioners, dentists, optometrists, chiropractors, physiotherapists, podiatrists and osteopaths.)

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 needs to:

- clearly identify the name of the patient; and
 - contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
 - each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and
- each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

15.1.5 To be *contemporaneous*, the patient or clinical record should be completed at the time that the service was rendered or initiated 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).

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

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

A.3 Services Not Attracting Medicare Benefits

A.3.1 Telephone consultations, letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death 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.

A.5.7 For items 5906 to 5912 'implementation of a management plan' includes counselling services.

A.5.8 Items 5906 to 5912 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.5.9 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.5.10 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.5.11 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.5.12 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.5.13 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.5.14 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), Initial Consultations for NEW PATIENTS (Items 296 to 299) and Referral to Clinical Psychologists (for new and continuing patients)

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)

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.

Initial Consultation for a NEW PATIENT (item 296 in rooms, item 297 at hospital, and item 299 for home visits)

A.15.6 The rationale for new items 296 - 299 is to improve access to psychiatric services by encouraging an increase in the number of new patients seen by each psychiatrist, while acknowledging that ongoing care of patients with severe mental illness is integral to the role of the psychiatrist. Referral for new items 296 - 299 may be from a medical practitioner practising in general practice, a specialist or another consultant physician.

A.15.7 It is intended that either item 296, 297 or 299 will apply once only for each new patient on the first occasion that the patient is seen by a consultant psychiatrist, **unless** the patient is referred by a medical practitioner practising in general practice for an assessment and management plan, in which case the consultant psychiatrist, if he or she agrees that the patient is suitable for management in a general practice setting, will use item 291 where an assessment and management plan is provided to the referring practitioner.

A.15.8 It is acknowledged that there may be particular circumstances where a medical practitioner practising in general practice has referred a patient (who is a new patient to the consultant psychiatrist) for an assessment and management plan, but it is not possible for the consultant psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, item 296, 297 or 299 may be used, and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a further consultation (in accordance with the item requirements) and provides the referring medical practitioner with an assessment and management plan. It is not generally intended that item 296, 297 or 299 will be used in conjunction with, or prior to, item 291.

A.15.9 Use of items 296 - 299 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient.

A.15.10 Items 300 - 308 will continue to be available for consultations in consulting rooms other than those provided under item 296, and items 291 - 293. Similarly time tiered items remain available for hospital and home visits. These would cover a new course of attention for patients who have already been seen by the consultant psychiatrist in the preceding 24 months as well as subsequent consultations for all patients.

Referral to Clinical Psychologists (for new and continuing patients)

A.15.11 To increase the clinical treatment options available to consultant psychiatrists for which a Medicare benefit is payable, patients may be referred to a clinical psychologist for a total of 12 sessions of psychological therapies in a calendar year. These services should be provided, as required, in up to two groups of six sessions with the need for the second group of sessions to be reviewed by the consultant psychiatrist after the initial sessions.

A.15.12 While such referrals are likely to occur for new patients seen under items 296 - 299, they are also available for patients at any point in treatment, as clinically required, under the same arrangements and limitations as outlined in A.15.11.

A.15.13 Patients are eligible for up to 12 Medicare-rebatable services of psychological therapies per calendar year when referred by a consultant psychiatrist, with the provision for a further referral for up to an additional six services to be made in exceptional circumstances. In such cases, the patient's referral should be annotated to briefly indicate the reason why the additional services were required in excess of the 12 services permitted within a calendar year.

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 CHILD HEALTH CHECK (ITEM 708)

A.21.17 The purpose of this Child Health Check is to ensure that Aboriginal and Torres Strait Islander children receive the optimum level of health care by encouraging prevention, early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality.

A.21.18 This item applies to an Aboriginal and/or Torres Strait Islander person who is less than 15 years old. It complements the existing health assessments, available to Aboriginal and Torres Strait Islander people aged 15 years and over.

A.21.19 The Child Health Check will be undertaken in the context of a number of existing activities that are undertaken for children by a range of care providers, particularly in the first year of life. The health check complements these activities, but does not replace them.

A.21.20 It is recommended that the Aboriginal and Torres Strait Islander Child Health Check be provided annually. However, to allow some flexibility in timing, a minimum period of 9 months has been set. This will also allow medical practitioners to provide health checks more frequently during the first few years of a patient's life. The Child Health Check should not replace existing routine neonatal and 6-8 week baby checks. An optimum time to commence the Child Health Check may be in the 4-6 month age group, as this is the age where growth faltering is more likely to occur.

A.21.21 Aboriginal and Torres Strait Islander children have higher rates of death, illness and hospitalisations than non-Indigenous children at all ages. Respiratory infections are the leading cause of hospitalisation for Aboriginal and Torres Strait Islander infants and children, and are a major cause of excess deaths. Sudden infant death syndrome, injuries and infectious diseases are also significant causes of excess deaths. Aboriginal and Torres Strait Islander children are more likely than non-Indigenous children to be born with a low birth weight and as a consequence are more at risk of associated illness. Aboriginal and Torres Strait Islander children have higher rates of otitis media than non-Indigenous children, and in some communities skin infections, gastrointestinal infections, malnutrition, acute rheumatic fever and rheumatic heart disease are significant causes of morbidity.

A.21.22 Aboriginal and Torres Strait Islander children are more likely than non-Indigenous children to be exposed to life stress events such as illness, hospitalisation, death of a close family member, family separation and family financial difficulties. They are also more likely to be cared for by a person with a long term health condition. Children in these circumstances are at higher risk of clinically significant emotional or behavioural difficulties. Assessment of life stress events and emotional and social wellbeing are an important component of the Aboriginal and Torres Strait Islander Child Health check.

A.21.23 An Aboriginal and Torres Strait Islander Child Health Check means the assessment of an Aboriginal and/or Torres Strait Islander patient's health and physical, psychological and social function, and determining what preventive health care, education and other assistance should be offered to that patient or the patient's parents/carer, to improve the patient's health and physical, psychological or social function.

A.21.24 This item does not apply to people who are in-patients of a hospital or day hospital 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.21.25 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, or is identified as such by their parent or carer. Patients or their parent or carer should be asked to identify their Aboriginal and/or Torres Strait Islander status for the purpose of these items, either verbally or by completing a form.

A.21.26 The Aboriginal and Torres Strait Islander Child 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.

A.21.27 Before the health check is commenced, the patient or their parent or carer 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.

A.21.28 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, including presentations and recurrent admissions, where these are available, before undertaking the health check.

A.21.29 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 or their parent or carer has agreed to the Child Health Check and has agreed to a third party collecting information for the assessment;
- (b) the patient or their parent or carer is told whether or not information collected about them for the health check will be retained by the third party; and
- (c) the third party acts under the supervision of the practitioner.

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

A.21.30 The medical practitioner should:

- (a) be satisfied that the person collecting information for the Child 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.21.31 An Aboriginal and Torres Strait Islander Child 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.

HISTORY

A.21.32 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.

A.21.33 Medical practitioners should also review information contained in the patient's child health record.

Mandatory Matters

A.21.34 The following list of items comprises those items that should be included in the patient's history as a minimum. The history should be appropriate for the age of the patient.

History:

- Mother's pregnancy
- Birth and neo-natal period
- Breastfeeding,
- Weaning, food access and dietary history
- Physical activity
- Medical history including previous presentations, hospital admissions and medication use
- Relevant family medical history
- Immunisation status
- Vision and hearing (including neonatal hearing screening)
- Development (achievement of age-appropriate milestones)
- Family relationships, social circumstances and whether the patient is cared for by another person
- Exposure to environmental factors, including tobacco smoke
- Environmental, and living conditions (eg. overcrowding)
- Educational progress
- Stressful life events
- Mood (eg, depression and self harm risk,)
- Substance use
- Sexual activity
- Dental hygiene and access to dental services
- Other history as considered necessary by the practitioner/collector

EXAMINATION

A.21.35 In examining the patient, the practitioner should consider the following matters.

Mandatory matters:	< 2 years	2-3 years	4-9 years	10-14 years
Height and weight (plot and interpret growth curve/calculate BMI),	✓	✓	✓	✓
Newborn baby check if not previously completed	✓			
Vision (red reflex in newborn)	✓			
Ear examination (otoscopy)	✓	✓	✓	✓
Teeth and gums		✓	✓	✓
Optional matters in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment.				
Trachoma check where indicated			✓	✓
Skin examination where indicated (scabies and skin sores)	✓	✓	✓	✓
Respiratory examination if indicated	✓	✓	✓	✓
Cardiac auscultation if indicated (congenital heart disease/rheumatic heart disease)	✓	✓	✓	✓
Developmental assessment (age appropriate milestones) where indicated	✓	✓	✓	✓
Assessment of parent-child interaction if indicated	✓	✓	✓	✓
Other examination as considered necessary by the practitioner	✓	✓	✓	✓

Investigations

A.21.36 Arrange or undertake investigations as clinically indicated and considered necessary by the practitioner in accordance with national or regional guidelines or specific regional needs.

A.21.37 Arrange haemoglobin testing for children at high risk of anaemia and ensure audiometry is conducted when required and at, or just before, school entry.

A.21.38 Practitioners should ensure that the results of investigations undertaken for the health check are followed up, consistent with good clinical practice.

Assessment of patient

A.21.39 The overall assessment of the patient must be based on consideration of evidence from the 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.

INTERVENTION

A.21.40 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.

A.21.41 The practitioner must assess risk factors and should discuss those risk factors with the patient or their parent or carer. The practitioner should provide or arrange for preventive health advice and intervention activity as indicated. This should be evidence-based, and may include arranging for activity and services by other local health and care providers.

A.21.42 Depending on age and condition, interventions may include:

- Treatment as required
- Follow-up as required
- Referral as required, including to dental providers
- Family-focussed intervention as appropriate
- Liaison with the patient's school and other service provider, as required
- Home visiting program referral
- Immunisation as recommended
- Advice on breast feeding, diet and nutrition
- SIDS prevention advice
- Injury prevention advice
- Parenting advice
- Sun protection advice
- Physical activity advice
- Safe sex advice
- Substance use (including tobacco) prevention and treatment
- Other interventions as considered necessary

A.21.43 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 or their parent or carer and must be documented in the report about the health check.

A.21.44 The health check must also include keeping a record of the health check, and offering the patient or their parent or carer 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. The practitioner should ensure that this is communicated in a way that is understood by, and acceptable to the patient or their parent or carer.

A.21.45 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.21.46 If not already in place, it is recommended that practitioners establish a patient information register and recall system for their patients seeking an annual health check, and remind registered patients when their next health check is due.

A.21.47 ABORIGINAL AND TORRES STRAIT ISLANDER ADULT HEALTH CHECK (Item 710)

A.21.48 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.

A.21.49 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.

A.21.50 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).

A.21.51 Cervical cancer remains a significant cause of death in this under-screened population.

A.21.52 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.

A.21.53 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.21.54 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.21.55 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.21.56 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.21.57 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.

A.21.58 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.

A.21.59 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.21.60 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.

A.21.61 The other components of the health check must include a personal attendance by the medical practitioner.

A.21.62 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.21.63 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.

HISTORY

A.21.64 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.

A.21.65 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.

A.21.66 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.

EXAMINATION

A.21.67 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 proteinuria.

A.21.68 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.

INVESTIGATIONS AS REQUIRED

A.21.69 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.

A.21.70 Practitioners should ensure that the results of investigations undertaken for the health check are followed up, consistent with good clinical practice.

ASSESSMENT OF PATIENT

A.21.71 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.

INTERVENTION

A.21.72 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.

A.21.73 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.

A.21.74 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.21.75 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.

A.21.76 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.21.77 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.21.78 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.21.79 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.21.80 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.21.81 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.21.82 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.21.83 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.21.84 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.21.85 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.21.86 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.21.87 **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.21.88 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.21.89 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.21.90 **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.21.91 **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.21.92 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.21.93 **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.21.94 **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.21.95 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.21.96 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.21.97 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.21.98 HEALTH ASSESSMENTS FOR REFUGEES AND OTHER HUMANITARIAN ENTRANTS (Items 714 and 716)

A.21.99 The purpose of this health assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system, as soon as possible after their arrival in Australia (within twelve months of arrival). Some new refugees and other humanitarian entrants may have little experience of western health care systems; some may not know what a General Practitioner is or does. Some may have complex and unusual conditions as a result of their area of origin or living conditions prior to arrival in Australia, where communicable diseases such as tuberculosis, hepatitis, parasitic infections and human immunodeficiency virus(HIV) and other sexually transmitted infection's (STI) may be endemic. Many will have been exposed to war, famine, repression, torture and/or extreme poverty.

A.21.100 The aim of the assessment is to develop a detailed history and undertake a physical examination of the patient to identify immediate and long term health care needs and to initiate treatment. Patients can also be introduced to preventative health care in Australia, in particular immunisation, maternal and child health care and breast and cervical screening.

A.21.101 The health assessment complements other Medicare Benefits Schedule items for services that medical practitioners can provide, including normal consultations and enhanced primary care items for ongoing management of patients with chronic conditions.

A.21.102 A maximum of one Medicare rebate is payable for a health assessment per refugee or other humanitarian entrant.

A.21.103 For the purpose of this item, the health assessment applies to humanitarian entrants who are resident in Australia with access to Medicare services; this includes Refugees, Special Humanitarian Program and Protection Program entrants with the following visas:

- Offshore Refugee Category including:
 - 200 Refugee
 - 201 In Country Special Humanitarian
 - 203 Emergency rescue
 - 204 Women at Risk
- Offshore – Special Humanitarian Program
 - 202 Global Special Humanitarian
- Offshore – Temporary Humanitarian Visas (THV) including:
 - 447 Secondary Movement Offshore Entry Temporary
 - 451 Secondary Movement Relocation Temporary
 - 786 Temporary Humanitarian Concern
- Onshore Protection Program including:
 - 866 Permanent protection Visa (PPV)
 - 785 Temporary Protection Visa (TPV)

A.21.104 Patients should be asked to provide proof of their visa status and date of arrival in Australia. Alternatively, medical practitioners may telephone Medicare Australia on 132011, with the patient present, to check eligibility.

A.21.105 This item does not apply to in-patients of a hospital or day hospital facility or care recipients in residential aged care facilities.

A.21.106 A health assessment means an assessment of a patient's health and physical, psychological and social function and whether preventative health care, education and other assistance should be offered to the patient, to improve that person's health and physical, psychological and social function.

A.21.107 The health assessment is a voluntary service; patients should be given an explanation of the health assessment process and its likely benefits before commencing the assessment. The patient's consent to a health assessment should be obtained as per normal practice for obtaining consent to medical services and noted on the patient record.

A.21.108 The medical practitioner and patient can use the services of a translator by accessing the Commonwealth Government's Translating and Interpreting Services (TIS) and the Doctors Priority Line. To be eligible for fee-free TIS and Doctors Priority Line, the medical practitioner must be in a private practice and provide a Medicare service to patients who do not speak English and are permanent residents.

A.21.109 Where the patient has a proposer the medical practitioner may find it useful to consider having them present for the health assessment or components of the health assessment (subject to the patient's agreement). The patient's proposer may be able to provide useful information on matters such as physical, psychological and social function.

A.21.110 When conducting a health assessment, where available, the medical practitioner should consider the results of any previous health checks that may have been undertaken as part of Australia's entry requirement.

A.21.111 The information collection component of the health assessment may be completed by a 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 health assessment 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 assessment 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 assessment must include a personal attendance by the medical practitioner.

A.21.112 The medical practitioner should:

- (a) be satisfied that the person collecting information 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 assessment and communicate to the patient their recommendations about matters covered by the health assessment.

A.21.113 The health assessment must include keeping a record of the health assessment, and offering the patient a written report about the health assessment.

A.21.114 Any follow up work following completion of the health assessment should be treated as a different service. 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.21.115 Where a component of the health assessment is conducted in consulting rooms (item 714) and a component is conducted in the patient's home, including by a third party acting under the supervision of the practitioner, (item 716) the latter item should be claimed.

Content of the Health Assessment

A.21.116 The health assessment should be undertaken in a culturally sensitive manner that is appropriate to the needs of the patient and must include:

- (a) taking the patient's medical history;
- (b) physically examining the patient;
- (c) undertaking or arranging any required investigations;
- (d) assessing the patient using the information gained at (a) to (c); and
- (e) developing a management plan to address any issues and/or conditions and for the good health of the patient, including making/arranging any necessary interventions or referrals to allied health providers and specialists (noting that this may involve a cost to the patient).

A.21.117 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, however, practitioners, where clinically appropriate, should consider the following:

History

- (a) Medical history: past/family history and perceived health status, medications, allergies, habits, chronic conditions.
- (b) Social/refugee history: country of origin, preferred language, secondary/host countries, refugee detention camps, trauma issues.
- (c) Immunisation history: for children consider full course and include on the Australian Child Immunisation Register; for teenagers consider measles, mumps and rubella vaccine, Hepatitis B, Meningococcal C; for adults consider serology and booster vaccines.
- (d) Nutritional Assessment: malnutrition, vitamin deficiency or anaemia.
- (e) Psychological history: depression, post traumatic stress disorder, grief, family separation, history of incarceration, torture, survivor guilt.

Examination

- (a) Physical: height, weight, body mass index, blood pressure, temperature, percentile chart for children.
- (b) Cardiac, respiratory and abdominal examination.
- (c) Dentition: caries, gum disease, decreased dentition.
- (d) Vision and hearing.
- (e) Other: scars or injuries.

Investigations as Required

A.21.118 Arrange or undertake investigations as clinically indicated, consider the need for the following tests, in particular:

- (a) Tests for iron deficiency, lipids, glucose, and hepatitis/rubella serology.
- (b) Urine: urinary tract infection, Chlamydia with pregnancy.
- (c) Others: faecal examination for parasites, serum vitamin D, HIV, chest x-ray and Mantoux skin test for tuberculosis.

A.21.119 Practitioners should ensure that the results of investigations undertaken for the health check are followed up, consistent with good clinical practice.

Assessment of Patient

A.21.120 The overall assessment of the patient should be based on the consideration of evidence from patient history, examination and results of any investigations. The list of diagnoses and/or problems from the health assessment should form the basis of any actions to be taken.

Management Plan

A.21.121 The management plan includes:

- (a) planned follow-up of issues and/or conditions found in history, examination and investigations, including initiating intervention activity to meet the identified needs of the patient;
- (b) initial recommendation of immunisation, diet, vitamins and medications;
- (c) consideration of referrals to allied health professionals, approved torture and trauma professionals and/or specialist clinics; and
- (d) consideration of contraception advice and review of pap smear/sexually transmitted disease screening.

Additional matters of particular relevance to refugees and other humanitarian entrants

A.21.122 The health assessment will usually cover additional matters of particular relevance to humanitarian entrants. This may include dental treatment, allied health referrals, advice on breast feeding, diet and nutrition, injury prevention advice, parenting advice, safe sex advice, substance use (including tobacco) prevention and treatment, or other interventions as considered necessary.

A.21.123 A desktop guide - Caring for Refugee Patients in General Practice - is available on the RACGP website at www.racgp.org.au.

A.21.124 45 YEAR OLD HEALTH CHECK (Item 717)

The purpose of this item is to support general practitioners (GPs) to focus on the health needs of their patients around 45 years of age who are at risk of developing a chronic disease. The aim of the health check is to assist with detection and prevention of chronic disease and enable early intervention strategies to be put in place where appropriate.

Eligible Population

A.21.125 The health check is targeted at people who are between 45 and 49 years of age (inclusive) who are at risk of developing a chronic disease.

Risk Factors

A.21.126 A patient must be at risk of developing a chronic disease. A chronic disease or 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.

A.21.127 The decision about whether an individual is at risk of developing a chronic disease rests with the clinical judgement of the GP, but a specific risk factor must be identified. Factors that the GP may consider include, but are not limited to:

- lifestyle risk factors, such as smoking, physical inactivity, poor nutrition or alcohol misuse;
- biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; or
- family history of a chronic disease.

A.21.128 Where possible, practices are encouraged to identify whether a patient is at risk of developing a chronic disease through normal patient management and examination of patient records.

A.21.129 In circumstances where the GP is unsure whether the patient is at risk of developing a chronic disease, for example, because the patient is new to the practice, the GP may choose either to:

- determine whether the patient has a risk factor and, if so, undertake the health check in the same visit (billed under item 717); or
- determine whether the patient has a risk factor as part of a consultation (billed under the appropriate attendance item) and, if so, undertake the health check during a subsequent visit (billed under item 717).

If the patient does not have a risk factor, the appropriate attendance item would be billed.

Limits

A.21.130 A Medicare rebate is payable for this item only once for any eligible patient. This item is not an annual health check.

A.21.131 If a GP is unsure whether a patient has already received this service, they may call Medicare Australia, with the patient present, on 132 011.

A.21.132 The item does not apply to admitted patients of a hospital or day-hospital facility.

Eligible practitioners

A.21.133 This item can be claimed by a medical practitioner, including a general practitioner but not including a specialist or consultant physician. In these notes, the term "GP" is used as a generic reference to a medical practitioner able to claim this item.

A.21.134 The health check should generally be undertaken by the patient's 'usual doctor', that is, the GP who has provided the majority of services to the patient in the past 12 months, or is likely to provide the majority of services in the following 12 months.

Components of the health check

A.21.135 The health check must include:

- information collection, including taking a patient history and undertaking examinations and investigations as required;
- making an overall assessment of the patient;
- interventions as indicated; and
- providing advice and information to the patient.

Information Collection

A.21.136 The health check must include taking a patient history (if one does not already exist) or updating an existing history. The examination should be tailored to the patient's individual needs and risk factors. Investigations should be undertaken or arranged as clinically indicated, in accordance with relevant guidelines (see below).

Assessment of Patient

A.21.137 The health check must include an overall assessment of the patient's health, based on the patient history, examinations and the results of any investigations. This could also include an assessment of the patient's readiness to make lifestyle changes.

Interventions

A.21.138 Where appropriate, arrangements need to be put in place for referrals and follow-up of any problems identified.

Advice and information to the patient

A.21.139 The patient must be provided with advice and information as part of the health check. This should include advice on strategies to achieve lifestyle and behaviour changes where appropriate, utilising, in particular, the Lifescripts resources.

Role of the GP

A.21.140 The GP is responsible for the overall health check provided to the patient. The GP is expected to take a primary role in the following activities:

- Reviewing and analysing the information collected.
- Making an overall assessment of the patient.
- Undertaking and arranging investigations.
- Making referrals and identifying appropriate follow-up.
- Providing advice to the patient.

Role of the practice nurse and other health professionals.

A.21.141 Practice nurses, Aboriginal Health Workers and other health professionals may assist GPs in performing the health check, in accordance with accepted medical practice and under the supervision of the GP.

This may include activities associated with:

- identifying eligible patients through examination of patient records and patient information systems used within the practice;
- information collection (such as measuring height, weight and blood pressure);
- providing patients with information about recommended interventions at the direction of the GP (such as information about community resources and support services in the local area, referral options).

Guidelines

A.21.142 In considering and addressing risk factors, GPs are encouraged to utilise relevant guidelines and resources, such as:

- the RACGP publications: "*SNAP – a population health guide to behavioural risk factors in general practice*"; "*Putting Prevention into Practice*" (the Green Book); and "*Guidelines for Preventive Activities in General Practice*" (the Red Book).
- the National Health and Medical Research Council's publication "*Overweight and Obesity in Adults: A Guide for General Practitioners*".
- the Department of Health and Ageing's *Lifescripts* guidelines and evidence cards, assessment tools and prescription pads.

Relationship with other items

A.21.143 This health check item cannot be claimed in conjunction with another GP attendance item on the same day, except where this is clinically required.

A.21.144 For patients with an existing chronic condition, the Chronic Disease Management (CDM) items (721-731) provide a suite of items for the management and review of chronic conditions. Where a patient has an existing chronic condition, it is up to the clinical judgement of the GP whether the patient should receive a health check under this item or be managed through other services.

A.21.145 Indigenous people are able to access a specific health check under the Aboriginal and Torres Strait Islander Adult Health Check item (710). GPs are encouraged to use item 710 where appropriate. Aboriginal and Torres Strait Islander people may also receive a health check under this item if they meet the patient eligibility requirements.

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.22.52 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.22.39 and A.22.40).

A.22.11 Where a patient has a mental disorder only, it is anticipated that they will be managed under the new GP Mental Health Care items (items 2710 – 2713). Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan, and to manage their mental disorder

through a GP Mental Health Care Plan (item 2710). In this case, both items can be used. Where a patient has a mental disorder as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) and the GP Mental Health Care items.

PREPARING A GP MANAGEMENT PLAN (GPMP) – (Item 721)

A.22.12 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.22.13 and meeting the relevant requirements listed under A.22.41 and A.22.42. 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.22.44). The service must include a personal attendance by the GP with the patient, as part of Item 721.

A.22.13 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.22.14 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.

A.22.15 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 or within three months of any other EPC chronic disease management item, other than in exceptional circumstances eg repeated discharge from hospital (see A.22.50 and A.22.51).

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

A.22.16 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.22.18 and meeting the relevant requirements listed under A.22.41 and A.22.42. 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.22.44). The service must include a personal attendance by the GP with the patient as part of item 723.

A.22.17 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.22.18 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.22.19 The collaboration between the coordinating GP and participating providers at A.22.18 (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.22.20 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.22.48).

A.22.21 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.22.22 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.22.23 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.22.24 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 or within three months of any other EPC chronic disease management item, other than in exceptional circumstances eg repeated discharge from hospital (see A.22.50 and A.22.51).

REVIEWING A GP MANAGEMENT PLAN – (Item 725)

A.22.25 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.22.26 and meeting the relevant requirements listed under A.22.41 and A.22.42. 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.22.44). The service must include a personal attendance by the GP with the patient, as part of item 725.

A.22.26 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.22.27 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.22.28 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.22.29 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.22.30 and meeting the relevant requirements listed under A.22.41 and A.22.42. 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.22.44). The service must include a personal attendance by the GP with the patient as part of item 727.

A.22.30 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.22.31 See A.22.19 and A.22.20 for information on collaboration and on the required number and roles of collaborating providers.

A.22.32 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.22.33 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.22.50 and A.22.51).

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.22.34 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.22.35.

A.22.35 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.22.36 See A.22.19 and A.22.20 on collaboration and communication.

A.22.37 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.22.38 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 or within three months of a previous claim for the same item or within three months of a claim for other CDM 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.22.39 This item, including the components of the service, is similar to Item 729 (see A.22.34 to A.22.38 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.22.40 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.22.41 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.22.42 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.22.43 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.22.44 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.22.45 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.22.46 A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

A.22.47 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.22.48 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.22.49 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.22.50 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.22.51 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.22.52 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 (Items 10950-10970 and 10975-10977)

The explanatory notes for Allied Health and Dental Care Services items have been moved to Category 8 – Miscellaneous Services in order to be located near the Item details for the respective item/s.

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.

A.25.6 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 A.25.6, "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
- (h) giving a copy of the summary of the conference to the patient's usual general practitioner; and
- (i) discussing the outcomes of the patient or the patient's agent.

A23.9 Organisation of a discharge case conference (items 830, 832 and 834), may be provided for private in-patients only, and must be organised by the medical practitioner who is providing in-patient care.

Participation in a case conference

A.25.10 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.25.11 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.25.12 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.25.13 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.25.14 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.25.15 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.25.16 It is expected that a patient would not normally require more than 5 case conferences in a 12 month period.

A.25.17 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 also known as Home Medicines 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.

A.27.18 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),
- (g) providing a copy for the resident's records and for the nursing staff of the Residential Aged Care Facility, and
- (h) 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 numbers 10994, 10995, 10998 or 10999 for Pap smears provided by practice nurses on behalf of a GP. Where a Pap smear is taken from an eligible patient by a practice nurse on behalf of a GP, the use of item 10995 or 10999 will initiate a cervical screening incentive payment through the Practice Incentives Program (PIP).

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 Medicare Australia PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip.

A.29 Completion of a cycle of care for patients with established 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 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

* Not required if the patient is blind or does not have both eyes.

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

Subsequent visits: measure weight.

*** Not required if the patient does not have both feet.

A.29.3 These requirements are based on the current general practice guidelines produced by Diabetes Australia and the Royal Australian College of General Practitioners (*Diabetes Management in General Practice*). 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 requirements of the cycle of care have 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 cycle 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 cycle.

A.29.6 The requirements for claiming this item are the minimum needed to provide good care for 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 a 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 a cycle care for individual patients. This incentive is only paid once every 11-13 month period 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 Medicare Australia PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip.

A.30 Completion of the Asthma Cycle of Care (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 Cycle of Care. 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 Cycle of Care must include:

- At least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation),
- Documented diagnosis and assessment of level of asthma control and severity of asthma,
- Review of the patient's use of and access to asthma-related medication and devices,
- Provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan - discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records),
- Provision of asthma self-management education to the patient, and
- Review of the written or documented asthma action plan.

The Asthma Cycle of Care 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 Cycle of Care does not preclude referral to a specialist, but a specialist consultation cannot be counted as one of the two visits.

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

These items will only be payable for the completion of one Asthma Cycle of Care for each eligible patient per 12 month period, unless a further Asthma Cycle of Care is clinically indicated by exceptional circumstances.

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

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 Cycle of Care

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 Cycle of Care as per A30.1.

The minimum requirements of the Asthma Cycle of Care may be carried out in two (2) visits or if necessary as many visits as clinically required. The National Asthma Council's website provides a guide for completion of the Asthma Cycle of Care.

The visit that completes the Asthma Cycle of Care 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.

A.30.5 A PIP Asthma Incentive is available for completing the minimum requirements of the Asthma Cycle of Care 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 Medicare Australia PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip.

For more detailed information regarding asthma diagnosis, assessment and best practice management refer to the National Asthma Council's website at www.NationalAsthma.org.au.

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.31.5 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 HIC PIP enquiry line on 1800 222 032 or www.hic.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 GP Mental Health Care Items (Items 2710 to 2713)

A.32.1 This note provides information on the new GP Mental Health Care items 2710, 2712, 2713. It includes an overview of the new items, patient and provider eligibility, what activities are involved in providing services rebated by these items, links to other Medicare items and additional claiming information.

Overview

A.32.2 These new items define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health workers. These items complement the new mental health items for psychiatrists (items 296 - 299), clinical psychologists (items 80000 - 80020) and allied mental health providers (items 80100 – 80170).

A.32.3 The new GP Mental Health Care items incorporate a model for best practice primary health care of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises:

- assess and plan;
- provide and/or refer for appropriate treatment and services;
- review and ongoing management as required.

Who can provide

A.32.4 The new GP Mental Health Care Plan, Review and Consultation items are available for use in general practice by medical practitioners, including general practitioners but excluding specialists or consultant physicians. The term ‘GP’ is used in these notes as a generic reference to medical practitioners able to claim these items.

A.32.5 It is strongly recommended that GPs providing mental health care using these items have appropriate mental health training, such as training recognised through the General Practice Mental Health Standards Collaboration. GP organisations support the value of appropriate mental health training for GPs using these items.

What patients are eligible - Mental Disorder

A.32.6 These items are for patients with a mental disorder who would benefit from a structured approach to the management of their care needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual’s cognitive, emotional or social abilities (Refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Care items.

A.32.7 These GP services are available to eligible patients in the community. GP Mental Health Care Plan and Review services can also be provided to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital, where the GP who provides the GP Mental Health Care item is providing in-patient care: in this case the item is claimed as an in-hospital service (at 75% MBS rebate). GPs are able to contribute to care plans for patients (including public patients being discharged from hospital) using item 729, Contribution to a Multidisciplinary Care Plan, and to care plans for residents of aged care facilities using item 731.

PREPARING A GP MENTAL HEALTH CARE PLAN – (Item 2710)

What is involved - Assess and Plan

A.32.8 A rebate can be claimed once the GP has undertaken an assessment and prepared a GP Mental Health Care Plan by completing the steps from A.32.9 to A.32.17 and meeting the relevant requirements listed under A.32.30 to A.32.39 (Additional Claiming Information). This item covers both the assessment and preparation of the GP Mental Health Care Plan. Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment and preparation of the GP Mental Health Care Plan or components thereof (subject to patient agreement).

A.32.9 *Assessment*

An assessment of a patient must include:

- recording the patient's agreement for the GP Mental Health Care Plan service;
- taking relevant history (biological, psychological, social) including the presenting complaint;
- conducting a mental state examination;
- assessing associated risk and any co-morbidity;
- making a diagnosis and/or formulation; and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

A.32.10 The assessment can be part of the same consultation in which the GP Mental Health Care Plan is developed, or can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Care Plan, they are part of the GP Mental Health Care Plan service and are included in item 2710.

A.32.11 In order to facilitate ongoing patient focussed management, an outcome measurement tool should be utilised during the assessment and the review of the GP Mental Health Care Plan, except where it is considered clinically inappropriate. The choice of outcome measurement tools to be used is at the clinical discretion of the practitioner. GPs using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training.

A.32.12 *Preparation of a GP Mental Health Care Plan*

In addition to assessment of the patient, preparation of a GP Mental Health Care Plan must include:

- discussing the assessment with the patient, including the mental health formulation and/or diagnosis;
- identifying and discussing referral and treatment options with the patient, including appropriate support services;
- agreeing goals with the patient – what should be achieved by the treatment - and any actions the patient will take;
- provision of psycho-education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Care Plan.

A.32.13 Treatment options can include referral to a psychiatrist; referral to a clinical psychologist for psychological therapies, or to an appropriately trained GP or allied mental health professional for provision of focussed psychological strategy services; pharmacological treatments; and coordination with community support and rehabilitation agencies, mental health services and other health professionals.

A.32.14 Patients may be referred for treatment and services under normal GP referral arrangements. In addition, once a GP Mental Health Care Plan has been completed and claimed on Medicare, a patient is eligible for access to up to twelve Medicare rebates per calendar year for clinical psychology or focussed psychological strategy services (with provision for exceptional circumstances, see A.32.27 to A.32.29). Patients will also be eligible to claim up to 12 separate services for the provision of group psychotherapy.

A.32.15 Where a patient is being referred for other treatment or services the necessary referrals should be made after the steps above have been addressed and the patient's GP Mental Health Care Plan has been completed. It should be noted that the patient's mental health care plan should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient.

A.32.16 On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the GP.

A.32.17 Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Care Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Care Plan Review item. A rebate for preparation of a GP Mental Health Care Plan will not be paid within 12 months of a previous claim for the patient for the same item or within 12 months of a claim for a 3 Step Mental Health Process (items 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708) or within three months following a claim for a review (item 2712), other than in exceptional circumstances (see A.32.38 – A.32.39).

REVIEWING A GP MENTAL HEALTH CARE PLAN – (Item 2712)

A.32.18 The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Care Plan has been prepared, along with ongoing management through the GP Mental Health Care Consultation item and/or standard consultation items. A patient's GP Mental Health Care Plan should be reviewed at least once.

A.32.19 A rebate can be claimed once the GP who prepared the patient's GP Mental Health Care Plan (or another GP in the same practice or in another practice where the patient has changed practices) has undertaken a systematic review of the patient's progress against the GP Mental Health Care Plan by completing the activities at A.32.20 to A.32.22 and meeting the relevant requirements listed under A.32.30 to A.32.39 (Additional Claiming Information). The review item can also be used where a psychiatrist has prepared a referred assessment and management plan (item 291), as if that patient had a GP Mental Health Care Plan. The review service must include a personal attendance by the GP with the patient.

A.32.20 The review must include:

- recording the patient's agreement for this service;
- a review of the patient's progress against the goals outlined in the GP Mental Health Care Plan;
- modification of the documented GP Mental Health Care Plan if required;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- re-administration of the outcome measurement 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 in most cases there will be other consultations between the patient and the GP as part of ongoing management.

A.32.21 The recommended frequency for the review service, allowing for variation in patients' needs, is:

- an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Care Plan; and
- if required, a further review can occur three months after the first review.

In general, most patients should not require more than two reviews in a 12 month period, with ongoing management through the GP Mental Health Care Consultation and standard consultation items, as required.

A.32.22 A rebate will not be paid within three months of a previous claim for the same item or within four weeks following a claim for a GP Mental Health Care Plan item other than in exceptional circumstances (see A.32.38 – A.32.39).

GP MENTAL HEALTH CARE CONSULTATION – (Item 2713)

A.32.23 The GP Mental Health Care Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health Care Plan. This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Care Plan.

A.32.24 A GP Mental Health Care Consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);
- providing treatment, advice and/or referral for other services or treatment; and
- documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

A.32.25 A patient may be referred from a GP Mental Health Care Consultation for other treatment and services as per normal GP referral arrangements. This does not include referral for Medicare rebateable services by focussed psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the GP under a GP Mental Health Care Plan or under a referred psychiatrist assessment and management plan (item 291).

A.32.26 Consultations associated with this item must be at least 20 minutes duration.

REFERRAL

A.32.27 Patients may be referred for treatment and services under normal GP referral arrangements. In addition, once a GP Mental Health Care Plan has been completed and claimed on Medicare, or a GP is managing a patient under a referred psychiatrist assessment and management plan (item 291), a patient is eligible for access to up to twelve Medicare rebates per calendar year for services by:

- clinical psychologists providing psychological therapies; or
- appropriately trained GPs or allied mental health professionals providing focussed psychological strategy (FPS) services.

Patients can also be referred for FPS services under Access to Allied Psychological Services (ATAPS), available through Divisions of General Practice.

In addition to the above services, patients will also be eligible to claim up to 12 separate services for the provision of group psychotherapy.

A.32.28 Referrals for patients with either a GP Mental Health Care Plan or referred psychiatrist assessment and management plan (item 291) should be provided, as required, in up to two groups of six sessions with the need for the second group of sessions to be reviewed by the GP after the initial six sessions. This can be done using a GP Mental Health Care Plan Review, a GP Mental Health Care Consultation or a standard consultation item.

A.32.29 Patients are eligible for up to twelve Medicare rebateable services per calendar year with provision for a further referral for up to an additional six services able to be made in exceptional circumstances. Where referrals are provided in exceptional circumstances, both the patient's mental health care plan and referral should be annotated to briefly indicate the reason why the service involved was required in excess of the 12 services permitted within a calendar year.

ADDITIONAL CLAIMING INFORMATION

A.32.30 Before proceeding with any GP Mental Health Care Plan or Review service 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; and
- (b) the patient's agreement to proceed is recorded.

A.32.31 Before completing any GP Mental Health Care Plan or Review service and claiming a benefit for that service, the GP must offer the patient a copy of the care plan or reviewed care plan and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The GP may, with the permission of the patient, provide a copy of the GP Mental Health Care Plan, or relevant parts of the plan, to other providers involved in the patient's care.

A.32.32 The GP Mental Health Care Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

- (a) if a GP Mental Health Care item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Care Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;
- (b) if a GP Mental Health Care Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Care Plan item should be claimed; and
- (c) if a consultation is for the purpose of a GP Mental Health Care Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

A.32.33 Where separate consultations are undertaken in conjunction with mental health consultations, 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.32.34 A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

A.32.35 All consultations conducted as part of the GP Mental Health Care items must be rendered by the GP. A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care.

Links to other Medicare Services

A.32.36 It is preferable that wherever possible patients have only one plan for primary care management of their mental disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

A.32.37 The Chronic Disease Management (CDM) care plan items (items 721, 723, 725, 727, 729 and 731) continue to be available for patients with chronic medical conditions, including patients with complex needs.

- Where a patient has a mental health condition only, it is anticipated that they will be managed under the new GP Mental Health Care items.
- Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan, and to manage their mental health condition through a GP Mental Health Care Plan. In this case, both items can be used.
- Where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) and the GP Mental Health Care items.

Exceptional circumstances

A.32.38 There are minimum time intervals for payment of rebates for GP Mental Health Care 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 requires a new GP Mental Health Care Plan or a new Review, rather than, for example, amending the existing GP Mental Health Care Plan.

A.32.39 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 from 1 November 2006

A.32.40 The 3 Step Mental Health Process items that can be used to trigger Service Incentives Payments for completion of a 3 Step Mental Health Process will run in parallel to the new GP Mental Health Care items from 1 November 2006 to 30 April 2007. These items cannot be used as well as the new GP Mental Health Care Plan and Review items. During the transition period GPs should choose to use the new items or the SIP trigger items, but not both for the same patient.

A.33 Provision of Focussed Psychological Strategies (Items 2721 - 2727)

A.33.1 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 Focussed Psychological Strategies to a patient must be made either in the context of a 3 Step Mental Health Process, a GP Mental Health Care Plan or a Psychiatrist Assessment and Management Plan.

Minimum Requirements

A.33.2 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.

A.33.3 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 as having satisfied the requirements for higher level mental health skills for provision of the service, as determined by the General Practice Mental Health Standards Collaboration.

A.33.4 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.

A.33.5 Patients will in general be permitted to claim Medicare rebates for up to 12 services (comprising two groups of up to six sessions) under these item numbers per calendar year, however in exceptional circumstances relating to the patient's clinical status, a further 6 services can be claimed per calendar year. After one group of six services, the practitioner managing either the 3 Step Mental Health Process, GP Mental Health Care Plan or Psychiatrist Assessment and Management Plan 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

A.33.6 It is expected that this service would be provided only for patients who are unable to attend the practice.

Specific Focussed Psychological Strategies

A.33.7 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 Disorder

A.33.8 A mental 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.

Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items.

A.34 Attendance by a recognised specialist or consultant physician in the specialty of pain medicine (2801, 2806, 2814, 2824, 2832, 2840) and Case conference by a recognised specialist or consultant physician in the specialty of pain medicine (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000).

A.34.1 Items 2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000, apply only to a service provided by a recognised specialist or consultant physician in the specialty of pain medicine, in relation to a pain patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

A.34.2 The conditions that apply to the Case Conferences items (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note A.25 for details of these conditions.

A.34.3 Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of pain medicine and that service is pain medicine, then the relevant items from the pain specialist group (2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) must be claimed. Services to patients who are not receiving pain medicine services should be claimed using the relevant attendance or case conferencing items.

A.34.4 Attendance by a recognised specialist or consultant physician in the specialty of palliative medicine (3005, 3010, 3014, 3018, 3023, 3028) and Case conference by a recognised specialist or consultant physician in the specialty of palliative medicine (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093).

A.34.5 Items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093, apply only to a service provided by a recognised specialist or consultant physician in the specialty of palliative medicine, in relation to a palliative patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

A.34.6 General Practitioners who are recognised specialist in the specialty of palliative medicine and are treating a referred palliative patient and claiming items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093 cannot access the GP Management Plan items (721 and 725) or Team Care Arrangement items (723 and 727) for that patient. The referring practitioner is able to provide these services.

A.34.7 The conditions that apply to the Case Conferences items (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note A.25 for details of these conditions.

A.34.8 Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of palliative medicine and that service is a palliative medicine service, then the relevant items from the palliative specialist group 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) must be claimed. Services to patients who are not receiving palliative care services should be claimed using the relevant attendance or case conferencing items.

A.35 Telepsychiatry

A.35.1 **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.35.2 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.35.3 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.35.4 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.35.5 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.35.6 **Geographical**

Telepsychiatry items 353 to 358 are available for use when a consultant psychiatrist is located in the following Statistical Local Areas (SLAs):

- M1 (Capital City Urban Centre)
 - M2 (Other Metropolitan Urban Centre population 100,000+)
 - R1 (Large Rural Centre population 25,000 to 99,000)
- And a referred patient is located in:
- R1 (Large Rural Centre population 25,000 to 99,000)
 - R2 (Small Rural Centre population 10,000 to 24,999)
 - R3 (Other Rural Area population <10,000)
 - Rem1 (Remote Centre population 5,000+)
 - Rem2 (Other remote area population <5,000+)

The consultant psychiatrist **cannot be located in the same SLA as the patient**. For example:

1. A consultant psychiatrist conducts telepsychiatry consultations with a patient from his/her consulting rooms in Sydney CBD to the patient who is located in Albury, NSW. The consultant also visits Albury once a month as part of a "fly-in, fly-out" psychiatry service. When the consultant is in Albury and a consultation is required, he/she must conduct a face-to-face session with the patient. If 4 telepsychiatry sessions have already been conducted the consultant psychiatrist would claim an item in the ranges 364 to 370. If less than 4 telepsychiatry sessions have been conducted then the psychiatrist would use the current items 300 to 308.
2. If a consultant psychiatrist is located in Ballarat and the patient is also in Ballarat, the consultant would not be permitted to claim Medicare items for a consultation via telepsychiatry.

A.35.7 **Formal Review**

A formal review mechanism will be developed to monitor the effectiveness of the Telepsychiatry items.

A.36 Attendances by Medical Practitioners who are Emergency Physicians (Items 501 to 536)

A.36.1 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.36.2 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.36.3 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

A.36.4 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.

A.36.5 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.

A37 Prolonged Attendance by an Emergency Physician in Treatment of a Critical Condition (Items 519 to 536)

A37.1 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.38 Case Conferences by Consultant Psychiatrists (855 to 866)

A.38.1 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.38.2 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.38.3 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.38.4 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A.38.5 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.38.6 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.38.8 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.38.7 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.38.8 For the purposes of A.38.5, "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.38.9 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.38.10 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.38.11 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.38.4 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.38.12 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.38.13 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

A.38.14 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.38.15 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)

A.39 Case conference by consultant physicians in geriatric/rehabilitation medicine (Item 880)

A.39.1 Item 880 applies only to a service provided by a consultant physician or a specialist in the specialty of Geriatric or Rehabilitation Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine or rehabilitation medicine. The service must be in relation to an admitted patient in a hospital (not including a patient in a day-hospital or residential aged care facility) who is receiving one of the following types of specialist care:

- geriatric evaluation and management (GEM), in which the clinical intent is to maximise health status and/or optimise the living arrangements for a patient with multidimensional medical conditions with disabilities and psychosocial problems, who is usually (but not always) an older patient; or
- rehabilitation care, in which the clinical intent is to improve the functional status of a patient with an impairment or disability.

A.39.2 Both types of care are evidenced by multi-disciplinary management and regular assessments against a plan with negotiated goals and indicative time-frames. A case conference is usually held on each patient once a week throughout the patient's admission, usually as part of a regular scheduled team meeting, at which all the inpatients under the consultant physician's care are discussed in sequence.

The specific responsibilities of the coordinating consultant physician or specialist are defined as:

- coordinating and facilitating the multidisciplinary team meeting;
- resolving any disagreement or conflict so that management consensus can be achieved;
- clarifying responsibilities; and
- ensuring that the input of participants and the outcome of the case conference is appropriately recorded.

A.39.3 The multidisciplinary team participating in the case conference must include a minimum of three formal inpatient care providers from different disciplines, including at least two providers from different allied health disciplines (listed at dot point 2 of A24.7). The consultant physician or specialist 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 can be counted toward the minimum of three.

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three formal inpatient care providers must be present for the whole of the case conference.

Prior informed consent must be obtained from the patient, or the patient's agent including informing the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

Item 880 is not payable more than once a week or on the same day as a claim for any of the physician discharge case conferencing items 830, 832, 834, 835, 837 and 838, in respect of a particular patient.

A.40 Attendances by Outer Metropolitan Specialist Trainees (Items 5906, 5908, 5910, 5912)

A.40.1 Items [5906, 5908, 5910, 5912] relate specifically to attendances rendered by medical practitioners who are:

- enrolled in and undertaking a training course in one of the approved specialist colleges listed in Schedule 4 of the *Health Insurance Regulations, 1975* (excluding the Royal Australian College of General Practitioners);
- undertaking a placement as part of a structured training program of an approved specialist college providing experience not available in teaching hospitals; and
- undertaking an accredited 'advanced' training placement, or a training placement approved by the Department of Health and Ageing, that fully counts towards training time and other formal requirements. Access to Medicare benefits by the outer metropolitan specialist trainee is limited to attendances provided to patients from outer metropolitan areas at the appropriate practice for a specified time period.

A.40.2 Items (5906, 5908, 5910, 5912) cover four categories of outer metropolitan specialist trainee 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.40.3 These attendance items cannot be used for the provision of normal aftercare refer to explanatory note T.8.7 in Category 3.

A.41 Neurosurgery Specialist Referred Consultation (Items 6007 to 6015)

A.41.1 From 1 November 2006 referred consultations provided by specialist neurosurgeons will be covered under items 6007 to 6015. These new items replace the use of specialist items 104 and 105 for referred consultations by neurosurgeons.

A.41.2 The neurosurgical consultation structure comprises an initial consultation (item 6007) and four categories of subsequent consultations (items 6009-6015). These categories relate to the time AND level of complexity of the attendance i.e

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

A.41.3 The following provides further guidance for neurosurgeons in utilising the appropriate items in common clinical situations:

- (i) Initial consultation item 6007 will replace item 104.
- (ii) Subsequent consultation items 6009-6015 will replace item 105

LEVEL 1

Item 6009 (subsequent consultation on a patient for 15 mins or less) covers a minor subsequent attendance which is straightforward in nature. Some examples of a minor attendance would include consulting with the patient for the purpose of issuing a repeat script for anticonvulsant medications or the routine review of a patient with a ventriculo-peritoneal shunt.

LEVEL 2

Item 6011 (subsequent consultation on a patient for a duration of between 16 to 30 mins) would involve an detailed and comprehensive examination of the patient which is greater in complexity than would be provided under item 6009, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Where a management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record included in the patient notes. Some examples of a detailed neurosurgical attendance would include:

- the reviewing of neuroimaging for the monitoring of a tumour or lesion and discussion of the results with the patient (e.g. meningioglioma, spinal cord tumour);
- consultation on a patient to review imaging for spinal cord/cauda equina/ nerve root compression from a disc prolapse and discussion of results; or
- consultation on a patient prior to insertion of a ventriculo-peritoneal shunt)

LEVEL 3

Item 6013 (subsequent consultation on a patient with complex neurological conditions for the duration of between 31 to 45 mins) should involve an extensive and comprehensive examination of the patient greater in complexity than under item 6011, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Item 6013 would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record be included in the patient notes. Some examples of an extensive neurosurgical attendance would include:

- an attendance on a patient prior to a craniotomy for cerebral tumour;
- surgery for spinal tumour;
- revision of spinal surgery;
- epilepsy surgery; or
- for the treatment of cerebral aneurysm.

Examination of such patients would include full cranial nerve examination or examination of upper and lower limb nervous system.

LEVEL 4

Item 6015 (subsequent consultation on a patient with complex neurological conditions for a duration of more than 45 mins) should involve an exhaustive examination of the patient that is more comprehensive than 6013 and any ordering or evaluation of investigations and include detailed relevant patient notes. It would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is thoroughly discussed with the patient and a written record be included in the patient notes. An exhaustive neurosurgical consultation includes:

- managing adverse neurological outcomes;
- detailed discussion when multiple modalities are available for treatment (e.g. clipping versus coiling for management of a cerebral aneurysm, surgical resection versus radiosurgery for cerebral tumour); or
- discussion where surgical intervention is likely to result in a neurological deficit but surgery is critical to patient's life or to stop progressive neurologic decline (e.g. cranial nerve dysfunction, motor dysfunction secondary to a cerebral or spinal cord lesion).

Examination of such patients would include exhaustive neurosurgical examination including full neurological examination (cranial nerves and limbs) or detailed 'focused examination' (e.g.: brachial plexus examination)

Complex neurosurgical problems referred to in items 6013 and 6016 include:

- deterioration in neurologic function following cranial or spinal surgery;
- presentation with new neurologic signs/symptoms; multifocal spinal and cranial disease (e.g. neurofibromatosis); or
- chronic pain states following spinal surgery (including discussion of other treatment options and referral to pain management)

NOTE: It is expected that informed financial consent be obtained from the patient where possible.

A.42 Cancer Care Case Conference (871-872)

A.42.1 For the purposes of these items:

- private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a non-melanoma skin cancer;
- the billing medical practitioner may be from any area of medical practice and must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians, allied health providers or support staff are not eligible to bill the item.
- only one practitioner is eligible to claim item 871 for each patient case conference. This should be the doctor who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating doctor.
- each billing practitioner must ensure that his or her patient is informed that a charge will be incurred for the case conference for which a Medicare rebate will be payable;
- participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link;

- suitable allied health practitioners would generally be from one of the following disciplines: aboriginal health care worker; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietician; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or, speech pathologist;
- in general, it is expected that no more than two case conferences per patient per year will be billed by a practitioner; and
- cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes eg community or discharge case conferences.

A.43 Non-directive Pregnancy Support Counselling Service (item 4001)

A.43.1 Overview of the Pregnancy Support Counselling initiative

The Pregnancy Support Counselling initiative commenced on 1 November 2006. It provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to women who are concerned about a current pregnancy, or a pregnancy that occurred in the preceding 12 months, by an eligible medical practitioner (including a general practitioner, but not including a specialist or consultant physician) or allied health professional on referral from a medical practitioner. The term 'GP' is used hereafter as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician) able to provide these services.

There are four new MBS items for the provision of non-directive pregnancy support counselling services:

- Item 4001 – services provided by an eligible GP;
- Item 81000 – services provided by an eligible psychologist;
- Item 81005 – services provided by an eligible social worker; and
- Item 81010 – services provided by an eligible mental health nurse.

These notes relate to provision of a non-directive pregnancy support counselling service by an eligible GP. Explanatory notes relating to items 81000-81010 inclusive are available at note M.8.

A.43.2 Non-directive counselling is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.

A.43.3 The service involves the GP undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

A.43.4 The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

Patient eligibility

A.43.5 Medicare rebates for non-directive pregnancy support counselling services provided using item 4001 are available to women who are concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months.

A.43.6 Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service provided.

Medicare benefits

A.43.7 Medicare benefits are payable for up to three non-directive pregnancy support counselling services per patient, per pregnancy, from any of the following items - 4001, 81000, 81005 and 81010 (see explanatory note M.8).

A.43.8 Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with Medicare Australia on 132 011. Alternatively, the GP may check with Medicare Australia (the patient must be present to give permission).

A.43.9 Item 10990 or item 10991 can also be claimed in conjunction with item 4001 provided the conditions of the relevant item, 10990 or 10991, are satisfied (see explanatory note M.1).

Minimum Requirements

A.43.10 This service may only be provided by a GP who has completed appropriate non-directive pregnancy counselling training.

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

LEVEL A		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$37.15	\$27.90
TWO	\$25.90	\$19.45
THREE	\$22.20	\$16.65
FOUR	\$20.30	\$15.25
FIVE	\$19.20	\$14.40
SIX	\$18.45	\$13.85
SEVEN+	\$16.35	\$12.30

LEVEL B		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$54.55	\$40.95
TWO	\$43.30	\$32.50
THREE	\$39.60	\$29.70
FOUR	\$37.70	\$28.30
FIVE	\$36.60	\$27.45
SIX	\$35.85	\$26.90
SEVEN+	\$33.75	\$25.35

LEVEL C		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$83.40	\$62.55
TWO	\$72.15	\$54.15
THREE	\$68.45	\$51.35
FOUR	\$66.55	\$49.95
FIVE	\$65.45	\$49.10
SIX	\$64.70	\$48.55
SEVEN+	\$62.60	\$46.95

LEVEL D		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$112.20	\$84.15
TWO	\$100.95	\$75.75
THREE	\$97.25	\$72.95
FOUR	\$95.35	\$71.55
FIVE	\$94.25	\$70.70
SIX	\$93.50	\$70.15
SEVEN+	\$91.40	\$68.55

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/100% BENEFIT	75%
ONE	\$24.00	\$18.00
TWO	\$16.25	\$12.20
THREE	\$13.65	\$10.25
FOUR	\$12.35	\$ 9.30
FIVE	\$11.60	\$ 8.70
SIX	\$11.10	\$ 8.35
SEVEN+	\$9.20	\$ 6.90

STANDARD		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$33.50	\$25.15
TWO	\$24.75	\$18.60
THREE	\$21.85	\$16.40
FOUR	\$20.35	\$15.30
FIVE	\$19.50	\$14.65
SIX	\$18.90	\$14.20
SEVEN+	\$16.70	\$12.55

LONG		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$51.00	\$38.25
TWO	\$43.25	\$32.45
THREE	\$40.65	\$30.50
FOUR	\$39.35	\$29.55
FIVE	\$38.60	\$28.95
SIX	\$38.10	\$28.60
SEVEN+	\$36.20	\$27.15

PROLONGED		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$73.00	\$54.75
TWO	\$65.25	\$48.95
THREE	\$62.65	\$47.00
FOUR	\$61.35	\$46.05
FIVE	\$60.60	\$45.45
SIX	\$60.10	\$45.10
SEVEN+	\$58.20	\$43.65

AFTER HOURS ATTENDANCES

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

LEVEL A		
PATIENTS	FEE	BENEFITS 100%
ONE	\$47.55	\$47.55
TWO	\$36.30	\$36.30
THREE	\$32.60	\$32.60
FOUR	\$30.70	\$30.70
FIVE	\$29.60	\$29.60
SIX	\$28.85	\$28.85
SEVEN+	\$26.75	\$26.75

LEVEL B		
PATIENTS	FEE	BENEFITS 100%
ONE	\$64.95	\$64.95
TWO	\$53.70	\$53.70
THREE	\$50.00	\$50.00
FOUR	\$48.10	\$48.10
FIVE	\$47.00	\$47.00
SIX	\$46.25	\$46.25
SEVEN+	\$44.15	\$44.15

LEVEL C		
PATIENTS	FEE	BENEFITS 100%
ONE	\$93.80	\$93.80
TWO	\$82.55	\$82.55
THREE	\$78.85	\$78.85
FOUR	\$76.95	\$76.95
FIVE	\$75.85	\$75.85
SIX	\$75.10	\$75.10
SEVEN+	\$73.00	\$73.00

LEVEL D		
PATIENTS	FEE	BENEFITS 100%
ONE	\$122.60	\$122.60
TWO	\$111.35	\$111.35
THREE	\$107.65	\$107.65
FOUR	\$105.75	\$105.75
FIVE	\$104.65	\$104.65
SIX	\$103.90	\$103.90
SEVEN+	\$101.80	\$101.80

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

BRIEF		
PATIENTS	FEE	BENEFITS 100%
ONE	\$34.00	\$34.00
TWO	\$26.25	\$26.25
THREE	\$23.65	\$23.65
FOUR	\$22.35	\$22.35
FIVE	\$21.60	\$21.60
SIX	\$21.10	\$21.10
SEVEN+	\$19.20	\$19.20

STANDARD		
PATIENTS	FEE	BENEFITS 100%
ONE	\$43.50	\$43.50
TWO	\$34.75	\$34.75
THREE	\$31.85	\$31.85
FOUR	\$30.35	\$30.35
FIVE	\$29.50	\$29.50
SIX	\$28.90	\$28.90
SEVEN+	\$26.70	\$26.70

LONG		
PATIENTS	FEE	BENEFITS 100%
ONE	\$61.00	\$61.00
TWO	\$53.25	\$53.25
THREE	\$50.65	\$50.65
FOUR	\$49.35	\$49.35
FIVE	\$48.60	\$48.60
SIX	\$48.10	\$48.10
SEVEN+	\$46.20	\$46.20

PROLONGED		
PATIENTS	FEE	BENEFITS 100%
ONE	\$83.00	\$83.00
TWO	\$75.25	\$75.25
THREE	\$72.65	\$72.65
FOUR	\$71.35	\$71.35
FIVE	\$70.60	\$70.60
SIX	\$70.10	\$70.10
SEVEN+	\$68.20	\$68.20

Services that attract the 100% Medicare rebate – as at 1 November 2006

Medicare Benefits Schedule (MBS) Group	Name of Group	Item numbers
Group A1 <i>(all items other than items 19, 33, 40, 50)</i>	General practitioner attendances to which no other item applies	1, 2, 601, 602, 3, 4, 13, 20, 23, 24, 25, 35, 36, 37, 38, 43, 44, 47, 48, 51
Group A2 <i>(all items other than items 87, 89, 90, 91)</i>	Other non-referred attendances to which no other item applies	52, 53, 54, 57, 58, 59, 60, 65, 81, 83, 84, 86, 92, 93, 95, 96, 97, 98, 697, 698
Group A5	Prolonged attendances to which no other item applies	160, 161, 162, 163, 164
Group A6	Group therapy	170, 171, 172
Group A7	Acupuncture	173, 193, 195, 197, 199
Group A14	Health assessments	700, 702, 704, 706, 708, 710, 712, 714, 716, 717
Group A15 <i>(all items other than items 746, 749, 757, 768, 771, 773, 820-866)</i>	Multidisciplinary care plans and multidisciplinary case conferences	721, 723, 725, 727, 729, 731, 734, 736, 738, 740, 742, 744, 759, 762, 765, 775, 778, 779
Group A17	Medication management review	900, 903
Group A18	General practitioner attendances associated with Practice Incentives Program (PIP) payments	2497, 2501, 2503, 2504, 2506, 2507, 2509, 2517, 2518, 2521, 2522, 2525, 2526, 2546, 2547, 2552, 2553, 2558, 2559, 2574, 2575, 2577, 2578
Group A19	Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies	2598, 2600, 2603, 2606, 2610, 2613, 2616, 2620, 2622, 2624, 2631, 2633, 2635, 2664, 2666, 2668, 2673, 2675, 2677, 2704, 2705, 2707, 2708
Group A20	GP mental health care	2710, 2712, 2713, 2721, 2723, 2725, 2727
Group A27	Pregnancy support counselling	4001
Group A22	General practitioner after-hours attendances to which no other item applies	5000, 5003, 5007, 5010, 5020, 5023, 5026, 5028, 5040, 5043, 5046, 5049, 5060, 5063, 5064, 5067
Group A23	Other non-referred after-hours attendances to which no other item applies	5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5240, 5243, 5247, 5248, 5260, 5263, 5265, 5267
Group M5	Services provided by a registered Aboriginal Health Worker on behalf of a medical practitioner	10988, 10989
Group M2	Services provided by a practice nurse on behalf of a medical practitioner	10993, 10994, 10995, 10996, 10998, 10999

ATTENDANCES		GENERAL PRACTITIONER
GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
EMERGENCY ATTENDANCES - AFTER HOURS		
EMERGENCY ATTENDANCE AFTER HOURS (on not more than 1 patient on 1 occasion)		
	Professional attendance AT A PLACE OTHER THAN CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance <i>other than an attendance between 11pm and 7am</i> , on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday <i>(See para A.5 and A.10 of explanatory notes to this Category)</i>	
1	Fee: \$112.50	Benefit: 75% = \$84.40 100% = \$112.50
	Professional attendance AT CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and <u>where it is necessary for the doctor to return to, and specially open, consulting rooms</u> for the attendance - each attendance <i>other than an attendance between 11pm and 7am</i> , on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday <i>(See para A.5 and A.10 of explanatory notes to this Category)</i>	
2	Fee: \$112.50	Benefit: 100% = \$112.50
	Professional attendance, at a place OTHER THAN CONSULTING ROOMS , where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week <i>between 11pm and 7am</i> <i>(See para A.5 and A.10 of explanatory notes to this Category)</i>	
601	Fee: \$132.55	Benefit: 75% = \$99.45 100% = \$132.55
	Professional attendance, AT CONSULTING ROOMS , where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and <u>where it is necessary for the doctor to return to, and specially open, consulting rooms</u> for the attendance - each attendance on any day of the week <i>between 11pm and 7am</i> <i>(See para A.5 and A.10 of explanatory notes to this Category)</i>	
602	Fee: \$132.55	Benefit: 100% = \$132.55
GENERAL PRACTITIONER ATTENDANCES		
LEVEL 'A'		
	Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	
	SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 of explanatory notes to this Category)</i>	
3	Fee: \$14.70	Benefit: 100% = \$14.70
	HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) <i>(See para A.5 of explanatory notes to this Category)</i> Derived Fee: The fee for item 3, plus \$22.45 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 \$1.65 per patient.	
4		
	CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient <i>(See para A.5 and A.6 of explanatory notes to this Category)</i> Derived Fee: The fee for item 3, plus \$22.45 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 \$1.65 per patient.	
13		
	CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient <i>(See para A.5 and A.7 of explanatory notes to this Category)</i> Derived Fee: The fee for item 3, plus \$22.45 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 \$1.65 per patient.	
19		

ATTENDANCES	GENERAL PRACTITIONER
20	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient <i>(See para A.5 and A.8 of explanatory notes to this Category)</i> Derived Fee: The fee for item 3, plus \$22.45 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 \$1.65 per patient.</p>
23	<p style="text-align: center;">LEVEL 'B'</p> <p>Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 of explanatory notes to this Category)</i> Fee: \$32.10 Benefit: 100% = \$32.10</p>
24	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) <i>(See para A.5 of explanatory notes to this Category)</i> Derived Fee: The fee for item 23, plus \$22.45 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 \$1.65 per patient.</p>
25	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient <i>(See para A.5 and A.6 of explanatory notes to this Category)</i> Derived Fee: The fee for item 23, plus \$22.45 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 \$1.65 per patient.</p>
33	<p>CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient <i>(See para A.5 and A.7 of explanatory notes to this Category)</i> Derived Fee: The fee for item 23, plus \$22.45 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 \$1.65 per patient.</p>
35	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient <i>(See para A.5 and A.8 of explanatory notes to this Category)</i> Derived Fee: The fee for item 23, plus \$22.45 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 \$1.65 per patient.</p>
36	<p style="text-align: center;">LEVEL 'C'</p> <p>Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 of explanatory notes to this Category)</i> Fee: \$60.95 Benefit: 100% = \$60.95</p>
37	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) <i>(See para A.5 of explanatory notes to this Category)</i> Derived Fee: The fee for item 36, plus \$22.45 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 \$1.65 per patient.</p>

ATTENDANCES	OTHER NON-REFERRED
GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
SURGERY CONSULTATIONS	
	(Professional attendance at consulting rooms)
52	BRIEF CONSULTATION of not more than 5 minutes duration Fee: \$11.00 Benefit: 100% = \$11.00
53	STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration Fee: \$21.00 Benefit: 100% = \$21.00
54	LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration Fee: \$38.00 Benefit: 100% = \$38.00
57	PROLONGED CONSULTATION of more than 45 minutes duration Fee: \$61.00 Benefit: 100% = \$61.00
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 <i>(See para A.6 of explanatory notes to this Category)</i> Derived Fee: An amount equal to \$8.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$8.50 plus \$.70 per patient
83	STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration <i>(See para A.6 of explanatory notes to this Category)</i> Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$.70 per patient
84	LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration <i>(See para A.6 of explanatory notes to this Category)</i> Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$.70 per patient
86	PROLONGED CONSULTATION of more than 45 minutes duration <i>(See para A.6 of explanatory notes to this Category)</i> Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$.70 per patient

ATTENDANCES	OTHER NON-REFERRED
87	<p style="text-align: center;">CONSULTATION AT A HOSPITAL</p> <p>(Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient</p> <p>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</p>
89	<p>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</p>
90	<p>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</p>
91	<p>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</p>
92	<p style="text-align: center;">CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY</p> <p>(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</p> <p>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</p>
93	<p>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</p>
95	<p>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</p>
96	<p>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</p>
	EMERGENCY ATTENDANCE - AFTER HOURS
97	<p style="text-align: center;">(on not more than 1 patient on 1 occasion)</p> <p>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 <i>other than an attendance between 11pm and 7am</i>, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday (See para A.10 of explanatory notes to this Category) Fee: \$97.95 Benefit: 75% = \$73.50 100% = \$97.95</p>
98	<p>Professional attendance AT CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and <u>where it is necessary for the doctor to return to, and specially open, consulting rooms</u> for the attendance - each attendance <i>other than an attendance between 11pm and 7am</i>, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday (See para A.10 of explanatory notes to this Category) Fee: \$97.95 Benefit: 100% = \$97.95</p>

ATTENDANCES	OTHER NON-REFERRED
697	<p>Professional attendance AT A PLACE OTHER THAN CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week <i>between 11pm and 7am</i> <i>(See para A.10 of explanatory notes to this Category)</i> Fee: \$116.15 Benefit: 75% = \$87.15 100% = \$116.15</p>
698	<p>Professional attendance AT CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and <u>where it is necessary for the doctor to return to, and specially open, consulting rooms</u> for the attendance - each attendance on any day of the week between <i>11pm and 7am</i> <i>(See para A.10 of explanatory notes to this Category)</i> Fee: \$116.15 Benefit: 100% = \$116.15</p>

SPECIALIST	SPECIALIST
GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	<p>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)</p>
104	<p>- INITIAL attendance in a single course of treatment, not being a service to which item 106 or 109 apply Fee: \$75.60 Benefit: 75% = \$56.70 85% = \$64.30</p>
105	<p>Each attendance SUBSEQUENT to the first in a single course of treatment Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30</p>
106	<p>- 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, 109 or 10801 to 10816 apply Fee: \$62.75 Benefit: 75% = \$47.10 85% = \$53.35</p>
	<p>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)</p>
107	<p>- INITIAL attendance in a single course of treatment Fee: \$110.90 Benefit: 75% = \$83.20 85% = \$94.30</p>
108	<p>Each attendance SUBSEQUENT to the first in a single course of treatment Fee: \$70.15 Benefit: 75% = \$52.65 85% = \$59.65</p>
109	<p>INITIAL SPECIALIST OPHTHALMOLOGIST PAEDIATRIC ATTENDANCE in a single course of treatment, being an attendance at which a comprehensive eye examination is performed on a child aged 8 years or under, or on a child aged 14 years or under with developmental delay, not being a service to which item 104, 106 or any of items 10801 to 10816 applies Fee: \$113.55 Benefit: 75% = \$85.20 85% = \$96.55</p>

CONSULTANT PHYSICIAN		CONSULTANT PHYSICIAN
GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
	CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - SURGERY OR HOSPITAL (Professional attendance at consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)	
110	- INITIAL attendance in a single course of treatment Fee: \$133.35 Benefit: 75% = \$100.05 85% = \$113.35	
116	- Each attendance (other than a service to which item 119 applies) SUBSEQUENT to the first in a single course of treatment Fee: \$66.75 Benefit: 75% = \$50.10 85% = \$56.75	
119	- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment <i>(See para A.11 of explanatory notes to this Category)</i> Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30	
	CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - HOME VISITS (Professional attendance at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)	
122	- INITIAL attendance in a single course of treatment Fee: \$161.85 Benefit: 75% = \$121.40 85% = \$137.60	
128	- Each attendance (other than a service to which item 131 applies) SUBSEQUENT to the first in a single course of treatment Fee: \$97.85 Benefit: 75% = \$73.40 85% = \$83.20	
131	- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment <i>(See para A.11 of explanatory notes to this Category)</i> Fee: \$70.45 Benefit: 75% = \$52.85 85% = \$59.90	

PROLONGED		PROLONGED	
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)			
	- For a period of not less than 1 hour but less than 2 hours (See para A.12 of explanatory notes to this Category)		
160	Fee: \$191.90	Benefit: 75% = \$143.95	100% = \$191.90
	- For a period of not less than 2 hours but less than 3 hours (See para A.12 of explanatory notes to this Category)		
161	Fee: \$319.80	Benefit: 75% = \$239.85	100% = \$319.80
	- For a period of not less than 3 hours but less than 4 hours (See para A.12 of explanatory notes to this Category)		
162	Fee: \$447.60	Benefit: 75% = \$335.70	100% = \$447.60
	- For a period of not less than 4 hours but less than 5 hours (See para A.12 of explanatory notes to this Category)		
163	Fee: \$575.65	Benefit: 75% = \$431.75	100% = \$575.65
	- For a period of 5 hours or more (See para A.12 of explanatory notes to this Category)		
164	Fee: \$639.65	Benefit: 75% = \$479.75	100% = \$639.65

GROUP THERAPY		GROUP THERAPY	
GROUP A6 - GROUP THERAPY			
FAMILY GROUP THERAPY			
(Professional attendance for the purpose of group therapy of not less than 1 hours duration given under the direct continuous supervision of a medical practitioner, other than a consultant physician in the practice of his or her specialty of psychiatry, involving members of a family and persons with close personal relationships with that family)			
170	- each group of 2 patients <i>(See para A.13 of explanatory notes to this Category)</i>	Fee: \$101.85 Benefit: 75% = \$76.40	100% = \$101.85
171	- each group of 3 patients <i>(See para A.13 of explanatory notes to this Category)</i>	Fee: \$107.30 Benefit: 75% = \$80.50	100% = \$107.30
172	- each group of 4 or more patients <i>(See para A.13 of explanatory notes to this Category)</i>	Fee: \$130.60 Benefit: 75% = \$97.95	100% = \$130.60

ACUPUNCTURE	ACUPUNCTURE
GROUP A7 - ACUPUNCTURE	
173	<p>ATTENDANCE at which ACUPUNCTURE is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed (See para A.14 of explanatory notes to this Category)</p> <p>Fee: \$21.65 Benefit: 75% = \$16.25 100% = \$21.65</p>
193	<p>Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, involving either:</p> <p>(i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; OR</p> <p>(ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies</p> <p>AND at which ACUPUNCTURE is performed by the 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)</p> <p>Fee: \$32.10 Benefit: 100% = \$32.10</p>
195	<p>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:</p> <p>(i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; OR</p> <p>(ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies</p> <p>AND at which ACUPUNCTURE is performed by the 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)</p> <p>Derived Fee: The fee for item 193, plus \$22.45 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 \$1.65 per patient.</p>
197	<p>Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, involving either:</p> <p>(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;</p> <p>OR</p> <p>(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</p> <p>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)</p> <p>Fee: \$60.95 Benefit: 100% = \$60.95</p>

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: \$89.75

Benefit: 100% = \$89.75

CONSULTANT PSYCHIATRIST	CONSULTANT PSYCHIATRIST
GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
+ 291	<p style="text-align: center;">CONSULTANT PSYCHIATRIST, REFERRED PATIENT ASSESSMENT AND MANAGEMENT</p> <p>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.</p> <p>An attendance of more than 45 minutes duration at consulting rooms during which:</p> <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> 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 <p>Not being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under this item (See para A.15 of explanatory notes to this Category)</p> <p>Fee: \$400.00 Benefit: 85% = \$340.00</p>
+ 293	<p style="text-align: center;">CONSULTANT PSYCHIATRIST, REVIEW OF REFERRED PATIENT ASSESSMENT AND MANAGEMENT</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> - 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 management 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 <p>Being an attendance on a patient in respect of whom, in the preceding 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)</p> <p>Fee: \$250.00 Benefit: 85% = \$212.50</p>
† 296	<p style="text-align: center;">CONSULTANT PSYCHIATRIST, INITIAL CONSULTATION ON A NEW PATIENT, CONSULTING ROOMS</p> <p>Professional attendance of more than 45 minutes by a consultant physician in the practice of his or her speciality of PSYCHIATRY where a patient is referred to him or her by a medical practitioner, and where the patient:</p> <ul style="list-style-type: none"> - is a new patient for this consultant psychiatrist; or - is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. <p>Not being an attendance on a patient in respect of whom payment has been made under this item, items 297 or 299, or any of items 300 to 346 or 353 to 370 in the preceding 24 month period (See para A.15 of explanatory notes to this Category)</p> <p>Fee: \$230.00 Benefit: 75% = \$172.50 85% = \$195.50</p>

CONSULTANT PSYCHIATRIST		CONSULTANT PSYCHIATRIST	
† 297	<p>CONSULTANT PSYCHIATRIST, INITIAL CONSULTATION ON A NEW PATIENT, HOSPITAL</p> <p>Professional attendance of more than 45 minutes at hospital by a consultant physician in the practice of his or her speciality of PSYCHIATRY where a patient is referred to him or her by a medical practitioner, and where the patient:</p> <ul style="list-style-type: none"> - is a new patient for this consultant psychiatrist; or - is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. <p>Not being an attendance on a patient in respect of whom payment has been made under this item, items 296 or 299 or any of items 300 to 346 or 353 to 370 in the preceding 24 month period (See para A.15 of explanatory notes to this Category)</p>	Fee: \$230.00	Benefit: 75% = \$172.50 85% = \$195.50
† 299	<p>CONSULTANT PSYCHIATRIST, INITIAL CONSULTATION ON A NEW PATIENT, HOME VISITS</p> <p>Professional attendance of more than 45 minutes at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her speciality of PSYCHIATRY where a patient is referred to him or her by a medical practitioner, and where the patient:</p> <ul style="list-style-type: none"> - is a new patient for this consultant psychiatrist; or - is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. <p>Not being an attendance on a patient in respect of whom payment has been made under this item, items 296 or 297, or any of items 300 to 346 or 353 to 370 in the preceding 24 month period (See para A.15 of explanatory notes to this Category)</p>	Fee: \$230.00	Benefit: 75% = \$172.50 85% = \$195.50
‡ 300	<p>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)</p> <ul style="list-style-type: none"> - An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. 	Fee: \$38.30	Benefit: 75% = \$28.75 85% = \$32.60
‡ 302	<ul style="list-style-type: none"> - 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 296, 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. 	Fee: \$76.40	Benefit: 75% = \$57.30 85% = \$64.95
‡ + 304	<ul style="list-style-type: none"> - 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 296, 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. 	Fee: \$117.60	Benefit: 75% = \$88.20 85% = \$100.00
‡ + 306	<ul style="list-style-type: none"> - 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 296, 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. 	Fee: \$162.35	Benefit: 75% = \$121.80 85% = \$138.00
‡ 308	<ul style="list-style-type: none"> - An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. 	Fee: \$188.30	Benefit: 75% = \$141.25 85% = \$160.10
‡ 310	<ul style="list-style-type: none"> - An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year. 	Fee: \$19.15	Benefit: 75% = \$14.40 85% = \$16.30
‡ 312	<ul style="list-style-type: none"> - 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 296, 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year. 	Fee: \$38.30	Benefit: 75% = \$28.75 85% = \$32.60
‡ + 314	<ul style="list-style-type: none"> - 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 296, 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year. 	Fee: \$58.85	Benefit: 75% = \$44.15 85% = \$50.05

CONSULTANT PSYCHIATRIST		CONSULTANT PSYCHIATRIST	
‡ +	- 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 296, 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year.		
316	Fee: \$81.30	Benefit: 75% = \$61.00	85% = \$69.15
‡	- An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 370 apply exceed 50 attendances in a calendar year.		
318	Fee: \$94.25	Benefit: 75% = \$70.70	85% = \$80.15
‡ +	- 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 296, 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)		
319	Fee: \$162.35	Benefit: 75% = \$121.80	85% = \$138.00
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: \$38.30	Benefit: 75% = \$28.75	85% = \$32.60
322	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at hospital Fee: \$76.40	Benefit: 75% = \$57.30	85% = \$64.95
+	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at hospital Fee: \$117.60	Benefit: 75% = \$88.20	85% = \$100.00
+	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at hospital Fee: \$162.35	Benefit: 75% = \$121.80	85% = \$138.00
328	- An attendance of more than 75 minutes duration at hospital Fee: \$188.30	Benefit: 75% = \$141.25	85% = \$160.10
CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, HOME VISITS			
(Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a medical practitioner)			
330	- An attendance of not more than 15 minutes duration where that attendance is at a place other than consulting rooms or hospital Fee: \$70.25	Benefit: 75% = \$52.70	85% = \$59.75
332	- An attendance of more than 15 minutes duration but not more than 30 minutes duration where that attendance is at a place other than consulting rooms or hospital Fee: \$110.20	Benefit: 75% = \$82.65	85% = \$93.70
+	- An attendance of more than 30 minutes duration but not more than 45 minutes duration where that attendance is at a place other than consulting rooms or hospital Fee: \$160.50	Benefit: 75% = \$120.40	85% = \$136.45
+	- An attendance of more than 45 minutes duration but not more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital Fee: \$194.20	Benefit: 75% = \$145.65	85% = \$165.10
338	- An attendance of more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital Fee: \$220.50	Benefit: 75% = \$165.40	85% = \$187.45

CONSULTANT PSYCHIATRIST	CONSULTANT PSYCHIATRIST
	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: \$43.60 Benefit: 75% = \$32.70 85% = \$37.10
344	- FAMILY GROUP PSYCHOTHERAPY on a group of 3 patients, EACH PATIENT Fee: \$57.90 Benefit: 75% = \$43.45 85% = \$49.25
346	- FAMILY GROUP PSYCHOTHERAPY on a group of 2 patients, EACH PATIENT Fee: \$85.55 Benefit: 75% = \$64.20 85% = \$72.75
	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 <i>(See para A.17 of explanatory notes to this Category)</i>
348	Fee: \$112.00 Benefit: 75% = \$84.00 85% = \$95.20
350	- An attendance of not less than 45 minutes duration <i>(See para A.17 of explanatory notes to this Category)</i> Fee: \$154.65 Benefit: 75% = \$116.00 85% = \$131.50
	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 <i>(See para A.17 of explanatory notes to this Category)</i>
352	Fee: \$112.00 Benefit: 75% = \$84.00 85% = \$95.20
	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. <i>(See para A.35 of explanatory notes to this Category)</i>
353	Fee: \$44.00 Benefit: 75% = \$33.00 85% = \$37.40
355	A telepsychiatry consultation of more than 15 minutes duration but not more than 30 minutes duration. <i>(See para A.35 of explanatory notes to this Category)</i> Fee: \$87.90 Benefit: 75% = \$65.95 85% = \$74.75
356	A telepsychiatry consultation of more than 30 minutes duration but not more than 45 minutes duration. <i>(See para A.35 of explanatory notes to this Category)</i> Fee: \$128.90 Benefit: 75% = \$96.70 85% = \$109.60
357	A telepsychiatry consultation of more than 45 minutes duration but not more than 75 minutes duration <i>(See para A.35 of explanatory notes to this Category)</i> Fee: \$177.85 Benefit: 75% = \$133.40 85% = \$151.20

CONSULTANT PSYCHIATRIST		CONSULTANT PSYCHIATRIST	
358	A telepsychiatry consultation of more than 75 minutes duration (See para A.35 of explanatory notes to this Category) Fee: \$216.65 Benefit: 75% = \$162.50 85% = \$184.20		
	<p>CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND TREATMENT FOLLOWING TELEPSYCHIATRY</p> <p>Professional attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, where:</p> <ul style="list-style-type: none"> -the patient is referred to him or her by a medical practitioner, -that attendance occurs following four telepsychiatry consultations (items 353 to 358), - where that attendance and any other attendance to which items 364 to 370 apply does not exceed three consultations per patient in a calendar year. -any other attendance to which items 300 to 308 and 353 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. <p>These items may only be used after every fourth telepsychiatry consultation conducted in accordance with items 353 to 358.</p> <p>A face-to-face attendance of not more than 15 minutes duration. (See para A.35 of explanatory notes to this Category)</p>		
364	Fee: \$38.30 Benefit: 75% = \$28.75 85% = \$32.60		
366	A face-to-face attendance of more than 15 minutes duration but not more than 30 minutes duration (See para A.35 of explanatory notes to this Category) Fee: \$76.40 Benefit: 75% = \$57.30 85% = \$64.95		
367	A face-to-face attendance of more than 30 minutes duration but not more than 45 minutes duration. (See para A.35 of explanatory notes to this Category) Fee: \$112.00 Benefit: 75% = \$84.00 85% = \$95.20		
369	A face-to-face attendance of more than 45 minutes duration but not more than 75 minutes duration (See para A.35 of explanatory notes to this Category) Fee: \$154.65 Benefit: 75% = \$116.00 85% = \$131.50		
370	A face-to-face attendance of more than 75 minutes duration. (See para A.35 of explanatory notes to this Category) Fee: \$188.30 Benefit: 75% = \$141.25 85% = \$160.10		

CONSULT OCCUPATIONAL PHYSICIAN		CONSULT OCCUPATIONAL PHYSICIAN	
GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES			
CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - SURGERY OR HOSPITAL (Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner)			
385	- INITIAL attendance in a single course of treatment (See para A.18 of explanatory notes to this Category) Fee: \$75.60	Benefit: 75% = \$56.70	85% = \$64.30
386	- Each attendance SUBSEQUENT to the first in a single course of treatment (See para A.18 of explanatory notes to this Category) Fee: \$37.95	Benefit: 75% = \$28.50	85% = \$32.30
CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - HOME VISITS (Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner)			
387	- INITIAL attendance in a single course of treatment (See para A.18 of explanatory notes to this Category) Fee: \$110.90	Benefit: 75% = \$83.20	85% = \$94.30
388	- Each attendance SUBSEQUENT to the first in a single course of treatment (See para A.18 of explanatory notes to this Category) Fee: \$70.15	Benefit: 75% = \$52.65	85% = \$59.65

GROUP A13 - PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

PUBLIC HEALTH PHYSICIAN ATTENDANCES - SURGERY	
	<p>(Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)</p> <p>- 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 <i>(See para A.24 of explanatory notes to this Category)</i></p>
+ 410	<p>Fee: \$17.25 Benefit: 75% = \$12.95 85% = \$14.70</p>
	<p>- 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 <i>(See para A.24 of explanatory notes to this Category)</i></p>
+ 411	<p>Fee: \$37.75 Benefit: 75% = \$28.35 85% = \$32.10</p>
	<p>- 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 <i>(See para A.24 of explanatory notes to this Category)</i></p>
+ 412	<p>Fee: \$71.65 Benefit: 75% = \$53.75 85% = \$60.95</p>
	<p>- 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 <i>(See para A.24 of explanatory notes to this Category)</i></p>
+ 413	<p>Fee: \$105.55 Benefit: 75% = \$79.20 85% = \$89.75</p>
PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS	
	<p>(Professional attendance at other than consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)</p> <p>- 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 <i>(See para A.24 of explanatory notes to this Category)</i></p>
414	<p>Derived Fee: The fee for item 410, plus \$22.45 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 \$1.65 per patient.</p>
	<p>- 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 <i>(See para A.24 of explanatory notes to this Category)</i></p>
415	<p>Derived Fee: The fee for item 411, plus \$22.45 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 \$1.65 per patient.</p>
	<p>- 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 <i>(See para A.24 of explanatory notes to this Category)</i></p>
416	<p>Derived Fee: The fee for item 412, plus \$22.45 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 \$1.65 per patient.</p>
	<p>- 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 <i>(See para A.24 of explanatory notes to this Category)</i></p>
417	<p>Derived Fee: The fee for item 413, plus \$22.45 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 \$1.65 per patient.</p>

ATTENDANCES		MEDICAL PRACTITIONER - SPORTS	
GROUP A16 - MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES			
SUBGROUP 1 - SURGERY CONSULTATIONS			
MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES - SURGERY LEVEL 1			
	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine		
	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management (See para A.26 of explanatory notes to this Category)		
+			
444	Fee: \$17.25	Benefit: 75% = \$12.95	85% = \$14.70
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: \$37.75	Benefit: 75% = \$28.35	85% = \$32.10
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: \$71.65	Benefit: 75% = \$53.75	85% = \$60.95
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: \$105.55	Benefit: 75% = \$79.20	85% = \$89.75
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 <u>where it is necessary for the doctor to return to, and specially open, consulting rooms</u> 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: \$132.30	Benefit: 75% = \$99.25	85% = \$112.50
	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine		
	Professional attendance, AT CONSULTING ROOMS , where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and <u>where it is necessary for the doctor to return to, and specially open, consulting rooms</u> 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: \$155.90	Benefit: 75% = \$116.95	85% = \$132.55

MEDICAL PRACTITIONER		EMERGENCY MEDICINE	
GROUP A21 - MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES			
SUBGROUP 1 - CONSULTATIONS			
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 1			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of a problem focussed history, limited examination, diagnosis and initiation of appropriate treatment interventions involving straightforward medical decision making. <i>(See para A.36 of explanatory notes to this Category)</i>			
501	Fee: \$30.20	Benefit: 75% = \$22.65	85% = \$25.70
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 2			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency medicine physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems and the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of low complexity. <i>(See para A.36 of explanatory notes to this Category)</i>			
503	Fee: \$51.05	Benefit: 75% = \$38.30	85% = \$43.40
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 3			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of moderate complexity. <i>(See para A.36 of explanatory notes to this Category)</i>			
507	Fee: \$85.80	Benefit: 75% = \$64.35	85% = \$72.95
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 4			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of a detailed history, detailed examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of moderate complexity. <i>(See para A.36 of explanatory notes to this Category)</i>			
511	Fee: \$121.35	Benefit: 75% = \$91.05	85% = \$103.15
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 5			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of a comprehensive history, comprehensive examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of high complexity. <i>(See para A.36 of explanatory notes to this Category)</i>			
515	Fee: \$187.90	Benefit: 75% = \$140.95	85% = \$159.75

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.37 of explanatory notes to this Category)

519 **Fee:** \$129.15 **Benefit:** 75% = \$96.90 85% = \$109.80

-For a period of not less than 1 hour but less than 2 hours of total physician time spent with each patient

(See para A.37 of explanatory notes to this Category)

520 **Fee:** \$248.15 **Benefit:** 75% = \$186.15 85% = \$210.95

-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.37 of explanatory notes to this Category)

530 **Fee:** \$406.70 **Benefit:** 75% = \$305.05 85% = \$345.70

-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.37 of explanatory notes to this Category)

532 **Fee:** \$565.25 **Benefit:** 75% = \$423.95 85% = \$501.35

-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.37 of explanatory notes to this Category)

534 **Fee:** \$724.00 **Benefit:** 75% = \$543.00 85% = \$660.10

-For a period of 5 hours or more of total physician time spent with each patient.

(See para A.37 of explanatory notes to this Category)

536 **Fee:** \$803.35 **Benefit:** 75% = \$602.55 85% = \$739.45

ENHANCED PRIMARY CARE	ENHANCED PRIMARY CARE
GROUP A14 - HEALTH ASSESSMENTS	
700	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) AT CONSULTING ROOMS for a health assessment - of a patient who is at least 75 years old - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or item 702, 704 or 706 <i>(See para A.21 of explanatory notes to this Category)</i> Fee: \$167.45 Benefit: 100% = \$167.45</p>
702	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY for a health assessment - of a patient who is at least 75 years old - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or item 700, 704 or 706 <i>(See para A.21 of explanatory notes to this Category)</i> Fee: \$236.85 Benefit: 100% = \$236.85</p>
704	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) AT CONSULTING ROOMS for a health assessment - of a patient who is at least 55 years old and of Aboriginal or Torres Strait Islander descent - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or item 700, 702 or 706 <i>(See para A.21 of explanatory notes to this Category)</i> Fee: \$167.45 Benefit: 100% = \$167.45</p>
706	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY, for a health assessment - of a patient who is at least 55 years old and of Aboriginal or Torres Strait Islander descent - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or item 700, 702 or 704 <i>(See para A.21 of explanatory notes to this Category)</i> Fee: \$236.85 Benefit: 100% = \$236.85</p>
708	<p>ABORIGINAL AND TORRES STRAIT ISLANDER CHILD 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 a child health check of a patient who is of Aboriginal or Torres Strait Islander descent and aged 0 to 14 years inclusive - not being a child health check of a patient in respect of whom, in the preceding 9 months, a payment has been made under this item <i>(See para A.21 of explanatory notes to this Category)</i> Fee: \$167.45 Benefit: 100% = \$167.45</p>
710	<p>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 <i>(See para A.21 of explanatory notes to this Category)</i> Fee: \$199.60 Benefit: 100% = \$199.60</p>
712	<p>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.</p> <p>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. <i>(See para A.21 of explanatory notes to this Category)</i> Fee: \$187.65 Benefit: 100% = \$187.65</p>

ENHANCED PRIMARY CARE	ENHANCED PRIMARY CARE
714	<p>HEALTH ASSESSMENT FOR REFUGEES AND OTHER HUMANITARIAN ENTRANTS</p> <p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) AT CONSULTING ROOMS for a health assessment of a patient that has been granted residency in Australia under the Humanitarian Program, not being a health assessment of a patient in respect of whom, a payment has been made under this item or item 700, 702, 712 or 716.</p> <p>Benefits are payable for a service provided to a patient within 12 months of them arriving in Australia or receiving residency (whichever is the later) Note: Benefits are payable on one occasion only for a service included in this item or item 716 (See para A.21 of explanatory notes to this Category)</p> <p>Fee: \$199.60 Benefit: 100% = \$199.60</p>
716	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY for a health assessment of a patient that has been granted residency in Australia under the Humanitarian Program, not being a health assessment of a patient in respect of whom, a payment has been made under this item or item 700, 702, 712 or 714.</p> <p>Benefits are payable for a service provided to a patient within 12 months of them arriving in Australia or receiving residency (whichever is the later) Note: Benefits are payable on one occasion only for a service included in this item or item 714 (See para A.21 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 714, plus \$22.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 714 plus \$1.65 per patient.</p>
† 717	<p>45 YEAR OLD HEALTH CHECK</p> <p>Attendance by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) AT A PLACE OTHER THAN A HOSPITAL to undertake a health check for a patient between the age of 45 and 49 (inclusive) at risk of developing a chronic disease.</p> <p>Benefits are payable on one occasion only for each eligible patient. (See para A.21 of explanatory notes to this Category)</p> <p>Fee: \$100.00 Benefit: 100% = \$100.00</p>

CHRONIC DISEASE MANAGEMENT		CHRONIC DISEASE MANAGEMENT	
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	<p>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).</p> <p>A rebate will not be paid within twelve months of a previous claim for the same item, 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)</p> <p>Fee: \$124.95 Benefit: 75% = \$93.75 100% = \$124.95</p>		
‡ 723	<p>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).</p> <p>A rebate will not be paid within twelve months of a previous claim for the same item, 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)</p> <p>Fee: \$98.95 Benefit: 75% = \$74.25 100% = \$98.95</p>		
725	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to REVIEW:</p> <p>(a) a GP MANAGEMENT PLAN prepared by that medical practitioner (or an associated medical practitioner) to which item 721 applies; or</p> <p>(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).</p> <p>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)</p> <p>Fee: \$62.50 Benefit: 75% = \$46.90 100% = \$62.50</p>		
727	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to COORDINATE a REVIEW of</p> <p>(a) TEAM CARE ARRANGEMENTS coordinated by that medical practitioner (or an associated medical practitioner) to which item 723 applies; or</p> <p>(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).</p> <p>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)</p> <p>Fee: \$62.50 Benefit: 75% = \$46.90 100% = \$62.50</p>		
‡ 729	<p>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).</p> <p>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, item 727, 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)</p> <p>Fee: \$43.40 Benefit: 100% = \$43.40</p>		

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
‡ 731	<p>CONTRIBUTION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to:</p> <p>(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</p> <p>(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).</p> <p>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, 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.</p> <p><i>(See para A.22 of explanatory notes to this Category)</i></p> <p>Fee: \$43.40 Benefit: 100% = \$43.40</p>
SUBGROUP 2 - CASE CONFERENCES	
CASE CONFERENCE - MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN)	
734	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND COORDINATE 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)</p> <p><i>(See para A.23 of explanatory notes to this Category)</i></p> <p>Fee: \$83.75 Benefit: 100% = \$83.75</p>
736	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND COORDINATE 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)</p> <p><i>(See para A.23 of explanatory notes to this Category)</i></p> <p>Fee: \$125.65 Benefit: 100% = \$125.65</p>
738	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND COORDINATE 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)</p> <p><i>(See para A.23 of explanatory notes to this Category)</i></p> <p>Fee: \$167.45 Benefit: 100% = \$167.45</p>
740	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND COORDINATE 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)</p> <p><i>(See para A.23 of explanatory notes to this Category)</i></p> <p>Fee: \$83.75 Benefit: 100% = \$83.75</p>
742	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND COORDINATE 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)</p> <p><i>(See para A.23 of explanatory notes to this Category)</i></p> <p>Fee: \$125.65 Benefit: 100% = \$125.65</p>
744	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND COORDINATE 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)</p> <p><i>(See para A.23 of explanatory notes to this Category)</i></p> <p>Fee: \$167.45 Benefit: 100% = \$167.45</p>
746	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND COORDINATE 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</p> <p><i>(See para A.23 of explanatory notes to this Category)</i></p> <p>Fee: \$83.75 Benefit: 75% = \$62.85 85% = \$71.20</p>

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
749	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND COORDINATE 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)</p> <p>Fee: \$125.65 Benefit: 75% = \$94.25 85% = \$106.85</p>
757	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND COORDINATE 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)</p> <p>Fee: \$167.45 Benefit: 75% = \$125.60 85% = \$142.35</p>
759	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE, (other than to organise and coordinate 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)</p> <p>Fee: \$59.80 Benefit: 100% = \$59.80</p>
762	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and coordinate 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)</p> <p>Fee: \$95.70 Benefit: 100% = \$95.70</p>
765	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and coordinate 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)</p> <p>Fee: \$131.55 Benefit: 100% = \$131.55</p>
768	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE (other than to organise and coordinate 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)</p> <p>Fee: \$59.80 Benefit: 75% = \$44.85 85% = \$50.85</p>
771	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE (other than to organise and coordinate 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)</p> <p>Fee: \$95.70 Benefit: 75% = \$71.80 85% = \$81.35</p>
773	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE (other than to organise and coordinate 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)</p> <p>Fee: \$131.55 Benefit: 75% = \$98.70 85% = \$111.85</p>
775	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY, (other than to organise and coordinate 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)</p> <p>Fee: \$59.80 Benefit: 100% = \$59.80</p>

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
778	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY, (other than to organise and coordinate 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) <i>(See para A.23 of explanatory notes to this Category)</i> Fee: \$95.70 Benefit: 100% = \$95.70</p>
779	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY, (other than to organise and coordinate the conference), where the conference time is at least 45 minutes, (not being a service associated with a service to which item 730 applies) <i>(See para A.23 of explanatory notes to this Category)</i> Fee: \$131.55 Benefit: 100% = \$131.55</p>
820	<p style="text-align: center;">CASE CONFERENCE - CONSULTANT PHYSICIAN</p> <p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A 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 <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$122.90 Benefit: 75% = \$92.20 85% = \$104.50</p>
822	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A 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 <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$184.40 Benefit: 75% = \$138.30 85% = \$156.75</p>
823	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A 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) <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$245.75 Benefit: 75% = \$184.35 85% = \$208.90</p>
825	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and to coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$88.30 Benefit: 75% = \$66.25 85% = \$75.10</p>
826	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and to coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$140.80 Benefit: 75% = \$105.60 85% = \$119.70</p>
828	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and to coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$193.30 Benefit: 75% = \$145.00 85% = \$164.35</p>
830	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$122.90 Benefit: 75% = \$92.20 85% = \$104.50</p>

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
832	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$184.40 Benefit: 75% = \$138.30 85% = \$156.75</p>
834	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$245.75 Benefit: 75% = \$184.35 85% = \$208.90</p>
835	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$88.30 Benefit: 75% = \$66.25 85% = \$75.10</p>
837	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$140.80 Benefit: 75% = \$105.60 85% = \$119.70</p>
838	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.25 of explanatory notes to this Category)</i> Fee: \$193.30 Benefit: 75% = \$145.00 85% = \$164.35</p>
855	<p style="text-align: center;">CASE CONFERENCE - CONSULTANT PSYCHIATRIST</p> <p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE of at least 15 minutes, but less than 30 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.38 of explanatory notes to this Category)</i> Fee: \$122.90 Benefit: 75% = \$92.20 85% = \$104.50</p>
857	<p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE of at least 30 minutes, but less than 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.38 of explanatory notes to this Category)</i> Fee: \$184.40 Benefit: 75% = \$138.30 85% = \$156.75</p>
858	<p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE of at least 45 minutes with a multidisciplinary team of at least two other formal care providers, of different disciplines <i>(See para A.38 of explanatory notes to this Category)</i> Fee: \$245.75 Benefit: 75% = \$184.35 85% = \$208.90</p>
861	<p style="text-align: center;">CASE CONFERENCE - CONSULTANT PSYCHIATRIST</p> <p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE, of at least 15 minutes, but less than 30 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.38 of explanatory notes to this Category)</i> Fee: \$122.90 Benefit: 75% = \$92.20 85% = \$104.50</p>
864	<p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE, of at least 30 minutes, but less than 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.38 of explanatory notes to this Category)</i> Fee: \$184.40 Benefit: 75% = \$138.30 85% = \$156.75</p>

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
866	<p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE, of at least 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.38 of explanatory notes to this Category)</i> Fee: \$245.75 Benefit: 75% = \$184.35 85% = \$208.90</p>
† 871	<p style="text-align: center;">MULTIDISCIPLINARY CANCER CARE CASE CONFERENCE</p> <p>Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to LEAD AND COORDINATE A MULTIDISCIPLINARY CASE CONFERENCE ON A PATIENT WITH CANCER TO DEVELOP A MULTIDISCIPLINARY TREATMENT PLAN, where the case conference is of at least 10 minutes, with a multidisciplinary team of at least three other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers. <i>(See para A.42 of explanatory notes to this Category)</i> Fee: \$71.00 Benefit: 75% = \$53.25 85% = \$60.35</p>
† 872	<p>Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to PARTICIPATE IN A MULTIDISCIPLINARY CASE CONFERENCE ON A PATIENT WITH CANCER TO DEVELOP A MULTIDISCIPLINARY TREATMENT PLAN, where the case conference is of at least 10 minutes, with a multidisciplinary team of at least four medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers. <i>(See para A.42 of explanatory notes to this Category)</i> Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05</p>
880	<p style="text-align: center;">CASE CONFERENCE - CONSULTANT PHYSICIAN IN GERIATRIC OR REHABILITATION MEDICINE</p> <p>Attendance by a consultant physician in the practice of his or her specialty of GERIATRIC OR REHABILITATION MEDICINE, as a member of a case conference team, to COORDINATE A CASE CONFERENCE ON AN ADMITTED HOSPITAL PATIENT of at least 10 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.39 of explanatory notes to this Category)</i> Fee: \$42.95 Benefit: 75% = \$32.25</p>

GROUP A17 - DOMICILIARY MEDICATION MANAGEMENT REVIEW

900	<p>Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a Domiciliary Medication Management Review (DMMR) for patients living in the community setting, where the medical practitioner:</p> <ul style="list-style-type: none"> - assesses a patient's medication management needs, and following that assessment, refers the patient to a community pharmacy for a DMMR, and provides relevant clinical information required for the review, with the patient's consent; and - discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and - develops a written medication management plan following discussion with the patient. <p>Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR. (See para A.27 of explanatory notes to this Category)</p> <p>Fee: \$134.10 Benefit: 100% = \$134.10</p>
903	<p>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:</p> <ul style="list-style-type: none"> - 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 management plan and its implementation. <p>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)</p> <p>Fee: \$91.85 Benefit: 100% = \$91.85</p>

INCENTIVE ITEMS	GENERAL PRACTITIONER
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	<p style="text-align: center;">LEVEL 'A'</p> <p>Professional attendance involving taking a short patient history and, if required, limited examination and management</p> <p>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 items 10994, 10995, 10998 or 10999</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.28 of explanatory notes to this Category)</i></p> <p>Fee: \$14.70 Benefit: 100% = \$14.70</p>
‡ 2501	<p>LEVEL 'B'</p> <p>Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies;</p> <p>AND 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 items 10994, 10995, 10998 or 10999.</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.28 of explanatory notes to this Category)</i></p> <p>Fee: \$32.10 Benefit: 100% = \$32.10</p>
‡ 2503	<p>OUT-OF-SURGERY CONSULTATION</p> <p>(Professional attendance at a place other than consulting rooms). This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999. <i>(See para A.28 of explanatory notes to this Category)</i></p> <p>Derived Fee: The fee for item 2501, plus \$22.45 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 \$1.65 per patient.</p>
‡ 2504	<p>LEVEL 'C'</p> <p>Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies;</p> <p>AND 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 items 10994, 10995, 10998 or 10999.</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.28 of explanatory notes to this Category)</i></p> <p>Fee: \$60.95 Benefit: 100% = \$60.95</p>
‡ 2506	<p>OUT-OF-SURGERY CONSULTATION</p> <p>(Professional attendance at a place other than consulting rooms). This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999. <i>(See para A.28 of explanatory notes to this Category)</i></p> <p>Derived Fee: The fee for item 2504, plus \$22.45 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 \$1.65 per patient.</p>

LEVEL 'D'
 Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan;

AND 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 items 10994, 10995, 10998 or 10999.

SURGERY CONSULTATION
 (Professional attendance at consulting rooms)
(See para A.28 of explanatory notes to this Category)
Fee: \$89.75 **Benefit:** 100% = \$89.75

‡
2507

OUT-OF-SURGERY CONSULTATION
 (Professional attendance at a place other than consulting rooms). This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999.
(See para A.28 of explanatory notes to this Category)
Derived Fee: The fee for item 2507, plus \$22.45 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 \$1.65 per patient.

‡
2509

SUBGROUP 2 - COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS

The minimum requirements of care needed to be assessed to complete a cycle of care for patients with established 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

* Not required if the patient is blind or does not have both eyes.
 ** Initial visit: measure height and weight and calculate BMI as part of the initial patient assessment.
 Subsequent visits: measure weight.
 *** Not required if the patient does not have both feet.

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 a cycle of care for a patient with established diabetes mellitus

SURGERY CONSULTATION
 (Professional attendance at consulting rooms)
(See para A.29 of explanatory notes to this Category)
Fee: \$32.10 **Benefit:** 100% = \$32.10

‡
2517

OUT-OF-SURGERY CONSULTATION
 (Professional attendance at a place other than consulting rooms)

AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus
(See para A.29 of explanatory notes to this Category)
Derived Fee: The fee for item 2517, plus \$22.45 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 \$1.65 per patient.

‡
2518

INCENTIVE ITEMS	GENERAL PRACTITIONER
‡ 2521	<p style="text-align: center;">LEVEL 'C'</p> <p>Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies;</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.29 of explanatory notes to this Category) Fee: \$60.95 Benefit: 100% = \$60.95</p>
‡ 2522	<p>OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms)</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para A.29 of explanatory notes to this Category) Derived Fee: The fee for item 2521, plus \$22.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus \$1.65 per patient.</p>
‡ 2525	<p>LEVEL 'D'</p> <p>Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 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;</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.29 of explanatory notes to this Category) Fee: \$89.75 Benefit: 100% = \$89.75</p>
‡ 2526	<p>OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms)</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para A.29 of explanatory notes to this Category) Derived Fee: The fee for item 2525, plus \$22.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus \$1.65 per patient.</p>
SUBGROUP 3 - COMPLETION OF THE ASTHMA CYCLE OF CARE	
‡ 2546	<p>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 Cycle of Care is clinically indicated.</p> <p>At a minimum the Asthma Cycle of Care must include:</p> <ul style="list-style-type: none"> - at least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation) - documented diagnosis and assessment of level of asthma control and severity of asthma - review of the patient's use of and access to asthma related medication and devices - provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan – discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records) - provision of asthma self-management education to the patient - review of the written or documented asthma action plan <p>LEVEL 'B'</p> <p>Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies;</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care.</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.30 of explanatory notes to this Category) Fee: \$32.10 Benefit: 100% = \$32.10</p>

INCENTIVE ITEMS	GENERAL PRACTITIONER
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‡ 2547	<p>OUT-OF-SURGERY CONSULTATION</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care.</p> <p>(Professional attendance at a place other than consulting rooms) (See para A.30 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 2546, plus \$22.45 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 \$1.65 per patient.</p>
‡ 2552	<p style="text-align: center;">LEVEL 'C'</p> <p>Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies;</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care.</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.30 of explanatory notes to this Category)</p> <p>Fee: \$60.95 Benefit: 100% = \$60.95</p>
‡ 2553	<p>OUT-OF-SURGERY CONSULTATION</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care.</p> <p>(Professional attendance at a place other than consulting rooms) (See para A.30 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 2552, plus \$22.45 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 \$1.65 per patient.</p>
‡ 2558	<p style="text-align: center;">LEVEL 'D'</p> <p>Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 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;</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care.</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.30 of explanatory notes to this Category)</p> <p>Fee: \$89.75 Benefit: 100% = \$89.75</p>
‡ 2559	<p>OUT-OF-SURGERY CONSULTATION</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care.</p> <p>(Professional attendance at a place other than consulting rooms) (See para A.30 of explanatory notes to this Category)</p> <p>Derived Fee: The fee or item 2558, plus \$22.45 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 \$1.65 per patient.</p>

INCENTIVE ITEMS	GENERAL PRACTITIONER
SUBGROUP 4 - COMPLETION OF THE 3 STEP MENTAL HEALTH PROCESS	
<p>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.</p>	
<p>At a minimum the 3 Step Mental Health Process must include:</p>	
<ul style="list-style-type: none"> - 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. 	
<p>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.</p>	
LEVEL C	
<p>Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies;</p>	
<p>AND which <u>completes</u> the requirements of the 3 Step Mental Health Process.</p>	
SURGERY CONSULTATION	
(Professional attendance at consulting rooms)	
<i>(See para A.31 of explanatory notes to this Category)</i>	
2574	Fee: \$60.95 Benefit: 100% = \$60.95
OUT-OF-SURGERY CONSULTATION	
(Professional attendance at a place other than consulting rooms)	
<i>(See para A.31 of explanatory notes to this Category)</i>	
2575	Derived Fee: The fee for item 2574, plus \$22.45 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 \$1.65 per patient.
LEVEL 'D'	
<p>Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan;</p>	
<p>AND which <u>completes</u> the requirements of the 3 Step Mental Health Process.</p>	
SURGERY CONSULTATION	
(Professional attendance at consulting rooms)	
<i>(See para A.31 of explanatory notes to this Category)</i>	
2577	Fee: \$89.75 Benefit: 100% = \$89.75
OUT-OF-SURGERY CONSULTATION	
(Professional attendance at a place other than consulting rooms)	
<i>(See para A.31 of explanatory notes to this Category)</i>	
2578	Derived Fee: The fee for item 2577, plus \$22.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2577 plus \$1.65 per patient.

INCENTIVE ITEMS	OTHER NON-REFERRED
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	<p>SURGERY CONSULTATIONS</p> <p>(Professional attendance at consulting rooms)</p> <p>BRIEF CONSULTATION of not more than 5 minutes duration</p> <p>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 items 10994, 10995, 10998 or 10999 (See para A.28 of explanatory notes to this Category)</p> <p>Fee: \$11.00 Benefit: 100% = \$11.00</p>
‡ 2600	<p>SURGERY CONSULTATIONS</p> <p>(Professional attendance at consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND 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 items 10994, 10995, 10998 or 10999. (See para A.28 of explanatory notes to this Category)</p> <p>Fee: \$21.00 Benefit: 100% = \$21.00</p>
‡ 2603	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999. (See para A.28 of explanatory notes to this Category)</p> <p>Fee: \$38.00 Benefit: 100% = \$38.00</p>
‡ 2606	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999. (See para A.28 of explanatory notes to this Category)</p> <p>Fee: \$61.00 Benefit: 100% = \$61.00</p>
‡ 2610	<p>OUT-OF-SURGERY CONSULTATIONS</p> <p>(Professional attendance at a place other than consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999. (See para A.28 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$0.70 per patient</p>
‡ 2613	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999. (See para A.28 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$0.70 per patient</p>

INCENTIVE ITEMS	OTHER NON-REFERRED																								
‡ 2616	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999. <i>(See para A.28 of explanatory notes to this Category)</i></p> <p>Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$0.70 per patient</p>																								
<p style="text-align: center;">SUBGROUP 2 - COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS</p>																									
‡ 2620	<p>The minimum requirements of care needed to be assessed to complete a cycle of care for patients with established diabetes mellitus are:</p> <table border="0" data-bbox="220 622 1490 1012"> <tr> <td>- Assess diabetes control by measuring HbA_{1c}</td> <td>At least once every year</td> </tr> <tr> <td>- Ensure that a comprehensive eye examination is carried out*</td> <td>At least once every two years</td> </tr> <tr> <td>- Measure weight and height and calculate BMI**</td> <td>At least twice every cycle of care</td> </tr> <tr> <td>- Measure blood pressure</td> <td>At least twice every cycle of care</td> </tr> <tr> <td>- Examine feet***</td> <td>At least twice every cycle of care</td> </tr> <tr> <td>- Measure total cholesterol, triglycerides and HDL cholesterol</td> <td>At least once every year</td> </tr> <tr> <td>- Test for microalbuminuria</td> <td>At least once every year</td> </tr> <tr> <td>- Provide self-care education</td> <td>Patient education regarding diabetes management</td> </tr> <tr> <td>- Review diet</td> <td>Reinforce information about appropriate dietary choices</td> </tr> <tr> <td>- Review levels of physical activity</td> <td>Reinforce information about appropriate levels of physical activity</td> </tr> <tr> <td>- Check smoking status</td> <td>Encourage cessation of smoking (if relevant)</td> </tr> <tr> <td>- Review of medication</td> <td>Medication review</td> </tr> </table> <p>* Not required if the patient is blind or does not have both eyes. ** Initial visit: measure height and weight and calculate BMI as part of the initial patient assessment. Subsequent visits: measure weight. *** Not required if the patient does not have both feet.</p> <p>SURGERY CONSULTATIONS</p> <p>(Professional attendance at consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus. <i>(See para A.29 of explanatory notes to this Category)</i></p> <p>Fee: \$21.00 Benefit: 100% = \$21.00</p>	- Assess diabetes control by measuring HbA _{1c}	At least once every year	- Ensure that a comprehensive eye examination is carried out*	At least once every two years	- Measure weight and height and calculate BMI**	At least 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
- 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																								
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- Review levels of physical activity	Reinforce information about appropriate levels of physical activity																								
- Check smoking status	Encourage cessation of smoking (if relevant)																								
- Review of medication	Medication review																								
‡ 2622	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus <i>(See para A.29 of explanatory notes to this Category)</i></p> <p>Fee: \$38.00 Benefit: 100% = \$38.00</p>																								
‡ 2624	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus <i>(See para A.29 of explanatory notes to this Category)</i></p> <p>Fee: \$61.00 Benefit: 100% = \$61.00</p>																								

INCENTIVE ITEMS	OTHER NON-REFERRED
‡ 2631	<p>OUT-OF-SURGERY CONSULTATIONS</p> <p>(Professional attendance at a place other than the consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para A.29 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$0.70 per patient</p>
‡ 2633	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para A.29 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$0.70 per patient</p>
‡ 2635	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para A.29 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$0.70 per patient</p>
SUBGROUP 3 - COMPLETION OF THE ASTHMA CYCLE OF CARE	
‡ 2664	<p>Note: Benefits are payable for only one service included in Subgroup 3 or A18, Subgroup 3 in a 12-month period, unless a further Asthma Cycle of Care is clinically indicated.</p> <p>At a minimum the Asthma Cycle of Care must include:</p> <ul style="list-style-type: none"> - at least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation) - documented diagnosis and assessment of level of asthma control and severity of asthma - review of the patient's use of and access to asthma related medication and devices - provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan – discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records) - provision of asthma self-management education to the patient - review of the written or documented asthma action plan <p>SURGERY CONSULTATIONS</p> <p>(Professional attendance at consulting rooms)</p> <p>STANDARD CONSULTATIONS of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care. (See para A.30 of explanatory notes to this Category)</p> <p>Fee: \$21.00 Benefit: 100% = \$21.00</p>
‡ 2666	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care. (See para A.30 of explanatory notes to this Category)</p> <p>Fee: \$38.00 Benefit: 100% = \$38.00</p>
‡ 2668	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care. (See para A.30 of explanatory notes to this Category)</p> <p>Fee: \$61.00 Benefit: 100% = \$61.00</p>

INCENTIVE ITEMS	OTHER NON-REFERRED
‡ 2673	<p>OUT-OF-SURGERY CONSULTATIONS</p> <p>(Professional attendance at a place other than the consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care. (See para A.30 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$0.70 per patient.</p>
‡ 2675	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care. (See para A.30 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$0.70 per patient</p>
‡ 2677	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care. (See para A.30 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$0.70 per patient</p>
SUBGROUP 4 - COMPLETION OF THE 3 STEP MENTAL HEALTH PROCESS	
2704	<p>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.</p> <p>At a minimum the 3 Step Mental Health Process must include:</p> <ul style="list-style-type: none"> - 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. <p>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.</p> <p style="text-align: center;">SURGERY CONSULTATIONS</p> <p>(Professional attendance at consulting rooms)</p> <p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND which <u>completes</u> the requirements of the 3 Step Mental Health Process. (See para A.31 of explanatory notes to this Category)</p> <p>Fee: \$38.00 Benefit: 100% = \$38.00</p>
2705	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND which <u>completes</u> the requirements of the 3 Step Mental Health Process. (See para A.31 of explanatory notes to this Category)</p> <p>Fee: \$61.00 Benefit: 100% = \$61.00</p>

INCENTIVE ITEMS	OTHER NON-REFERRED
2707	<p style="text-align: center;">OUT-OF-SURGERY CONSULTATIONS</p> <p>(Professional attendance at a place other than the consulting rooms)</p> <p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND which <u>completes</u> the requirements of the 3 Step Mental Health Process. <i>(See para A.31 of explanatory notes to this Category)</i></p> <p>Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$0.70 per patient.</p>
2708	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND which <u>completes</u> the requirements of the 3 Step Mental Health Process. <i>(See para A.31 of explanatory notes to this Category)</i></p> <p>Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$0.70 per patient.</p>

MEDICAL PRACTITIONER	MEDICAL PRACTITIONER
GROUP A20 - GP MENTAL HEALTH CARE	
SUBGROUP 1 - GP MENTAL HEALTH CARE PLANS	
† 2710	<p>PREPARATION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) of a GP MENTAL HEALTH CARE PLAN for a patient (not being a service associated with a service to which items 2713 or 734 to 779 apply).</p> <p>A rebate will not be paid within twelve months of a previous claim for the same item, within twelve months of a claim for a 3 Step Mental Health Process (items 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708) or within three months following a claim for item 2712, 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 Mental Health Care Plan.</p> <p>(See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$150.00 Benefit: 75% = \$112.50 100% = \$150.00</p>
† 2712	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to REVIEW a GP MENTAL HEALTH CARE PLAN prepared by that medical practitioner (or an associated medical practitioner) to which item 2710 applies or to REVIEW a PSYCHIATRIST ASSESSMENT AND MANAGEMENT PLAN to which item 291 applies (not being a service associated with a service to which items 2713 or 734 to 779 apply).</p> <p>A rebate will not be paid within three months of a previous claim for the same item or within four weeks following a claim for item 2710, 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 Mental Health Care Plan.</p> <p>(See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$100.00 Benefit: 75% = \$75.00 100% = \$100.00</p>
† 2713	<p>Professional ATTENDANCE by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) involving taking relevant history, identifying presenting problem(s), providing treatment, advice and/or referral for other services or treatments and documenting the outcomes of the consultation, on a patient in relation to a mental disorder and lasting at least 20 minutes (not being a service associated with a service to which items 2710 or 2712 apply).</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$66.00 Benefit: 100% = \$66.00</p>
SUBGROUP 2 - FOCUSED PSYCHOLOGICAL STRATEGIES	
‡ + 2721	<p>MEDICAL PRACTITIONER ATTENDANCE (INCLUDING A GENERAL PRACTITIONER, BUT NOT INCLUDING A SPECIALIST OR CONSULTANT PHYSICIAN) ASSOCIATED WITH PROVISION OF FOCUSED PSYCHOLOGICAL STRATEGIES</p> <p>Note: These services may only be provided by a medical practitioner who is registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service. The medical practitioner must provide the service in a general practice participating in the PIP or which is accredited.</p> <p>Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies, that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These strategies are required to be provided to patients by a credentialed medical practitioner and are time limited; being deliverable, in general, in up to 12 planned sessions comprising two groups of up to six sessions. In exceptional circumstances, following review by the practitioner managing either the 3 Step Mental Health Process, the GP Mental Health Care Plan or the Psychiatric Assessment and Management Plan, up to a further 6 sessions may be approved in a calendar year 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.</p> <p>FPS ATTENDANCE Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental 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.</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.33 of explanatory notes to this Category)</p> <p>Fee: \$80.35 Benefit: 100% = \$80.35</p>

2723	<p>OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) <i>(See para A.33 of explanatory notes to this Category)</i> Derived Fee: The fee for item 2721, plus \$22.45 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 \$1.65 per patient.</p>
+ 2725	<p>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.</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.33 of explanatory notes to this Category)</i> Fee: \$115.00 Benefit: 100% = \$115.00</p>
2727	<p>OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) <i>(See para A.33 of explanatory notes to this Category)</i> Derived Fee: The fee for item 2725, plus \$22.45 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 \$1.65 per patient.</p>

PAIN AND PALLIATIVE MEDICINE		PAIN MEDICINE
GROUP A24 - PAIN AND PALLIATIVE MEDICINE		
SUBGROUP 1 - PAIN MEDICINE ATTENDANCES		
MEDICAL PRACTITIONER (PAIN MEDICINE SPECIALIST) ATTENDANCE - SURGERY OR HOSPITAL		
Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a medical practitioner		
- INITIAL attendance in a single course of treatment (See para A.34 of explanatory notes to this Category)		
2801	Fee: \$133.35	Benefit: 75% = \$100.05 85% = \$113.35
- Each attendance (other than a service to which item 2814 applies) SUBSEQUENT to the first in a single course of treatment (See para A.34 of explanatory notes to this Category)		
2806	Fee: \$66.75	Benefit: 75% = \$50.10 85% = \$56.75
- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment (See para A.34 of explanatory notes to this Category)		
2814	Fee: \$37.95	Benefit: 75% = \$28.50 85% = \$32.30
MEDICAL PRACTITIONER (PAIN MEDICINE SPECIALIST) ATTENDANCE - HOME VISIT		
Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a medical practitioner		
- INITIAL attendance in a single course of treatment (See para A.34 of explanatory notes to this Category)		
2824	Fee: \$161.85	Benefit: 85% = \$137.60
- Each attendance (other than a service to which item 2840 applies) SUBSEQUENT to the first in a single course of treatment (See para A.34 of explanatory notes to this Category)		
2832	Fee: \$97.85	Benefit: 85% = \$83.20
- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment (See para A.34 of explanatory notes to this Category)		
2840	Fee: \$70.45	Benefit: 85% = \$59.90
SUBGROUP 2 - PAIN MEDICINE CASE CONFERENCES		
CASE CONFERENCES - PAIN MEDICINE SPECIALIST		
Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE , where the conference time is 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 para A.34 of explanatory notes to this Category)		
2946	Fee: \$122.90	Benefit: 75% = \$92.20 85% = \$104.50
Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE , where the conference time is 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 para A.34 of explanatory notes to this Category)		
2949	Fee: \$184.40	Benefit: 75% = \$138.30 85% = \$156.75
Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE , where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (See para A.34 of explanatory notes to this Category)		
2954	Fee: \$245.75	Benefit: 75% = \$184.35 85% = \$208.90
Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE , (other than to organise and to coordinate the conference) where the conference time is 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.34 of explanatory notes to this Category)		
2958	Fee: \$88.30	Benefit: 75% = \$66.25 85% = \$75.10

PAIN AND PALLIATIVE MEDICINE		PALLIATIVE MEDICINE	
2972	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE , (other than to organise and to coordinate the conference) where the conference time is 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.34 of explanatory notes to this Category)	Fee: \$140.80	Benefit: 75% = \$105.60 85% = \$119.70
2974	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE , (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (See para A.34 of explanatory notes to this Category)	Fee: \$193.30	Benefit: 75% = \$145.00 85% = \$164.35
2978	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE , where the conference time is 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 para A.34 of explanatory notes to this Category)	Fee: \$122.90	Benefit: 75% = \$92.20 85% = \$104.50
2984	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE , where the conference time is 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 para A.34 of explanatory notes to this Category)	Fee: \$184.40	Benefit: 75% = \$138.30 85% = \$156.75
2988	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE , where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (See para A.34 of explanatory notes to this Category)	Fee: \$245.75	Benefit: 75% = \$184.35 85% = \$208.90
2992	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE , where the conference time is 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.34 of explanatory notes to this Category)	Fee: \$88.30	Benefit: 75% = \$66.25 85% = \$75.10
2996	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE , where the conference time is 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.34 of explanatory notes to this Category)	Fee: \$140.80	Benefit: 75% = \$105.60 85% = \$119.70
3000	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE , where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (See para A.34 of explanatory notes to this Category)	Fee: \$193.30	Benefit: 75% = \$145.00 85% = \$164.35
SUBGROUP 3 - PALLIATIVE MEDICINE ATTENDANCES			
MEDICAL PRACTITIONER (PALLIATIVE MEDICINE SPECIALIST) ATTENDANCE - SURGERY OR HOSPITAL			
Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a medical practitioner			
- INITIAL attendance in a single course of treatment (See para A.34 of explanatory notes to this Category)			
3005		Fee: \$133.35	Benefit: 75% = \$100.05 85% = \$113.35
- Each attendance (other than a service to which item 3014 applies) SUBSEQUENT to the first in a single course of treatment (See para A.34 of explanatory notes to this Category)			
3010		Fee: \$66.75	Benefit: 75% = \$50.10 85% = \$56.75

PAIN AND PALLIATIVE MEDICINE	PALLIATIVE MEDICINE
3069	<p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE, where the conference time is 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 para A.34 of explanatory notes to this Category)</p> <p>Fee: \$122.90 Benefit: 75% = \$92.20 85% = \$104.50</p>
3074	<p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE, where the conference time is 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 para A.34 of explanatory notes to this Category)</p> <p>Fee: \$184.40 Benefit: 75% = \$138.30 85% = \$156.75</p>
3078	<p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (See para A.34 of explanatory notes to this Category)</p> <p>Fee: \$245.75 Benefit: 75% = \$184.35 85% = \$208.90</p>
3083	<p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE, where the conference time is 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.34 of explanatory notes to this Category)</p> <p>Fee: \$88.30 Benefit: 75% = \$66.25 85% = \$75.10</p>
3088	<p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE, where the conference time is 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.34 of explanatory notes to this Category)</p> <p>Fee: \$140.80 Benefit: 75% = \$105.60 85% = \$119.70</p>
3093	<p>Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (See para A.34 of explanatory notes to this Category)</p> <p>Fee: \$193.30 Benefit: 75% = \$145.00 85% = \$164.35</p>

MEDICAL PRACTITIONER	MEDICAL PRACTITIONER
GROUP A27 - PREGNANCY SUPPORT COUNSELLING	
† 4001	<p>MEDICAL PRACTITIONER ATTENDANCE (INCLUDING A GENERAL PRACTITIONER, BUT NOT INCLUDING A SPECIALIST OR CONSULTANT PHYSICIAN) ASSOCIATED WITH PROVISION OF NON-DIRECTIVE PREGNANCY SUPPORT COUNSELLING SERVICES</p> <p>Professional attendance for the purpose of providing non-directive pregnancy support counselling to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by a medical practitioner registered with Medicare Australia as meeting the credentialling requirements for provision of this service, and lasting at least 20 minutes.</p> <p>This service may not be provided by a medical practitioner who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.</p> <p>To a maximum of 3 non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items – 4001, 81000, 81005 and 81010 (<i>see Explanatory note M.8</i>).</p> <p>SURGERY CONSULTATION (professional attendance at consulting rooms) (<i>See para A.43 of explanatory notes to this Category</i>)</p> <p>Fee: \$66.35 Benefit: 100% = \$66.35</p>

GENERAL PRACTITIONER	GENERAL PRACTITIONER
	GROUP A22 - GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
5000	<p style="text-align: center;">LEVEL 'A'</p> <p>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</p> <p>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. <i>(See para A.5 of explanatory notes to this Category)</i></p> <p>Fee: \$25.10 Benefit: 100% = \$25.10</p>
5003	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution. 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.) <i>(See para A.5 of explanatory notes to this Category)</i></p> <p>Derived Fee: The fee for item 5000, plus \$22.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus \$1.65 per patient.</p>
5007	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. 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.) <i>(See para A.5 and A.6 of explanatory notes to this Category)</i></p> <p>Derived Fee: The fee for item 5000, plus \$22.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus \$1.65 per patient.</p>
5010	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. 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.) <i>(See para A.5 and A.8 of explanatory notes to this Category)</i></p> <p>Derived Fee: The fee for item 5000, plus \$22.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus \$1.65 per patient</p>
5020	<p style="text-align: center;">LEVEL 'B'</p> <p>Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 5040, 5043, 5046, 5049, 5060, 5063, 5064 or 5067 applies</p> <p>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.) <i>(See para A.5 of explanatory notes to this Category)</i></p> <p>Fee: \$42.50 Benefit: 100% = \$42.50</p>
5023	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution. 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.) <i>(See para A.5 of explanatory notes to this Category)</i></p> <p>Derived Fee: The fee for item 5020, plus \$22.45 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 \$1.65 per patient.</p>
5026	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. 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.) <i>(See para A.5 and A.6 of explanatory notes to this Category)</i></p> <p>Derived Fee: The fee for item 5020, plus \$22.45 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 \$1.65 per patient.</p>

GENERAL PRACTITIONER	GENERAL PRACTITIONER
5028	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient 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.) <i>(See para A.5 and A.8 of explanatory notes to this Category)</i> Derived Fee: The fee for item 5020, plus \$22.45 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 \$1.65 per patient.</p>
5040	<p style="text-align: center;">LEVEL 'C'</p> <p>Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 5060, 5063, 5064 or 5067 applies.</p> <p>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.) <i>(See para A.5 of explanatory notes to this Category)</i> Fee: \$71.35 Benefit: 100% = \$71.35</p>
5043	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution). 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.) <i>(See para A.5 of explanatory notes to this Category)</i> Derived Fee: The fee for item 5040, plus \$22.45 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 \$1.65 per patient.</p>
5046	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. 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.) <i>(See para A.5 and A.6 of explanatory notes to this Category)</i> Derived Fee: The fee for item 5040, plus \$22.45 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 \$1.65 per patient.</p>
5049	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. 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.) <i>(See para A.5 and A.8 of explanatory notes to this Category)</i> Derived Fee: The fee for item 5040, plus \$22.45 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 \$1.65 per patient.</p>
5060	<p style="text-align: center;">LEVEL 'D'</p> <p>Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms. 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.) <i>(See para A.5 of explanatory notes to this Category)</i> Fee: \$100.15 Benefit: 100% = \$100.15</p>
5063	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution). 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.) <i>(See para A.5 of explanatory notes to this Category)</i> Derived Fee: The fee for item 5060, plus \$22.45 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 \$1.65 per patient.</p>

GENERAL PRACTITIONER	GENERAL PRACTITIONER
5064	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. 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.) <i>(See para A.5 and A.6 of explanatory notes to this Category)</i> Derived Fee: The fee for item 5060, plus \$22.45 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 \$1.65 per patient.</p>
5067	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. 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.) <i>(See para A.5 and A.8 of explanatory notes to this Category)</i> Derived Fee: The fee for item 5060, plus \$22.45 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 \$1.65 per patient.</p>

OTHER NON-REFERRED	OTHER NON-REFERRED
	GROUP A23 - OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	(Professional attendance at consulting rooms)
5200	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
	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)
5220	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
	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
5240	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. <i>(See para A.6 of explanatory notes to this Category)</i> 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. <i>(See para A.6 of explanatory notes to this Category)</i> 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

OTHER NON-REFERRED	OTHER NON-REFERRED
5247	<p>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. <i>(See para A.6 of explanatory notes to this Category)</i> 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</p>
5248	<p>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. <i>(See para A.6 of explanatory notes to this Category)</i> 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</p>
5260	<p style="text-align: center;">CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY</p> <p>(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</p> <p>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. <i>(See para A.8 of explanatory notes to this Category)</i> 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</p>
5263	<p>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. <i>(See para A.8 of explanatory notes to this Category)</i> 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</p>
5265	<p>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. <i>(See para A.8 of explanatory notes to this Category)</i> 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</p>
5267	<p>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. <i>(See para A.8 of explanatory notes to this Category)</i> 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</p>

GROUP A25 - OUTER METROPOLITAN SPECIALIST TRAINEES	
† 5906	Professional attendance of not more than 5 minutes duration SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 and A.40 of explanatory notes to this Category)</i> Fee: \$17.25 Benefit: 75% = \$12.95 85% = \$14.70
† 5908	Professional attendance of more than 5 minutes duration but not more than 20 minutes duration SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 and A.40 of explanatory notes to this Category)</i> Fee: \$37.75 Benefit: 75% = \$28.35 85% = \$32.10
† 5910	Professional attendance of more than 20 minutes duration but not more than 40 minutes duration SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 and A.40 of explanatory notes to this Category)</i> Fee: \$71.65 Benefit: 75% = \$53.75 85% = \$60.95
† 5912	Professional attendance of more than 40 minutes duration SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 and A.40 of explanatory notes to this Category)</i> Fee: \$105.55 Benefit: 75% = \$79.20 85% = \$89.75

GROUP A26 - NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
† 6007	<p>NEUROSURGERY SPECIALIST, REFERRED CONSULTATION, - SURGERY OR HOSPITAL</p> <ul style="list-style-type: none"> - Professional attendance at consulting rooms or hospital by a specialist practising in the specialty of neurosurgery, where the patient was referred to him or her by a medical practitioner. - Initial attendance in a single course of treatment. <i>(See para A.41 of explanatory notes to this Category)</i> <p>Fee: \$114.55 Benefit: 75% = \$85.95 85% = \$97.40</p>
† 6009	<p style="text-align: center;">LEVEL 1</p> <p>Each MINOR attendance SUBSEQUENT to the first in a single course of treatment.</p> <ul style="list-style-type: none"> - An attendance of not more than 15 minutes duration. <i>(See para A.41 of explanatory notes to this Category)</i> <p>Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30</p>
† 6011	<p style="text-align: center;">LEVEL 2</p> <p>Each attendance SUBSEQUENT to the first in a single course of treatment being an attendance involving a detailed and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems.</p> <ul style="list-style-type: none"> - An attendance of more than 15 minutes duration but not more than 30 minutes duration. <i>(See para A.41 of explanatory notes to this Category)</i> <p>Fee: \$75.60 Benefit: 75% = \$56.70 85% = \$64.30</p>
† 6013	<p style="text-align: center;">LEVEL 3</p> <p>Each attendance SUBSEQUENT to the first in a single course of treatment being an attendance involving an extensive and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems.</p> <ul style="list-style-type: none"> - An attendance of more than 30 minutes duration but not more than 45 minutes duration. <i>(See para A.41 of explanatory notes to this Category)</i> <p>Fee: \$104.75 Benefit: 75% = \$78.60 85% = \$89.05</p>
† 6015	<p style="text-align: center;">LEVEL 4</p> <p>Each attendance SUBSEQUENT to the first in a single course of treatment being an attendance involving an exhaustive and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems</p> <ul style="list-style-type: none"> - An attendance of more than 45 minutes duration. <i>(See para A.41 of explanatory notes to this Category)</i> <p>Fee: \$133.35 Benefit: 75% = \$100.05 85% = \$113.35</p>

CONTACT LENSES		CONTACT LENSES	
GROUP A9 - CONTACT LENSES - ATTENDANCES			
CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS			
<i>Note: Benefits may not be claimed under Item 10809 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons</i>			
ATTENDANCE FOR THE INVESTIGATION and EVALUATION of a patient for the fitting of CONTACT LENSES, with keratometry and testing with trial lenses and the issue of a prescription - 1 SERVICE IN ANY PERIOD OF 36 CONSECUTIVE MONTHS			
10801	- patients with myopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye (See para A.19 of explanatory notes to this Category)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40
10802	- 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)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40
10803	- patients with astigmatism of 3.0 dioptres or greater in 1 eye (See para A.19 of explanatory notes to this Category)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40
10804	- patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens (See para A.19 of explanatory notes to this Category)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40
10805	- patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para A.19 of explanatory notes to this Category)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40
10806	- patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system (See para A.19 of explanatory notes to this Category)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40
10807	- patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: (i) pathological mydriasis; or (ii) aniridia; or (iii) coloboma of the iris; or (iv) pupillary malformation or distortion; or (v) significant ocular deformity or corneal opacity whether congenital, traumatic or surgical in origin (See para A.19 of explanatory notes to this Category)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40
10808	- patients who, by reason of physical deformity, are unable to wear spectacles (See para A.19 of explanatory notes to this Category)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40
10809	- patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, where the condition is specified on the patient's account (See para A.19 of explanatory notes to this Category)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40
10816	ATTENDANCE FOR THE REFITTING OF CONTACT LENSES with keratometry and testing with trial lenses and the issue of a prescription, <u>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</u> (See para A.20 of explanatory notes to this Category)	Fee: \$107.50 Benefit: 75% = \$80.65	85% = \$91.40

CATEGORY 8 – MISCELLANEOUS SERVICES

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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 Medicare Australia 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 Medicare Australia 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)

M.1.11 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.

M.1.12 Item 10992 cannot be claimed in conjunction with item 10990 or 10991.

M.1.13 Where a Medicare benefit is not payable for a particular service the payment for item 10992 will not be paid for that service.

M.1.14 All GPs, whether vocationally registered or not, are eligible to claim the additional bulk billing payment.

M.1.15 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.

M.1.16 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.

M.1.17 Medicare Australia 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 in addition to the immunisation being administered by the practice nurse, the medical practitioner is able to claim for the professional service they provide to the patient.

M.2.9 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 in addition to the treatment by the practice nurse, the medical practitioner is 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 and preventive checks provided by a practice nurse (item 10994, 10995, 10998 and 10999)

M.2.20 Items 10994 and 10995 require taking of a Pap smear **and at least one** preventive check.

M.2.21 Item 10994 can be claimed by a medical practitioner (not including a specialist or consultant physician) where a Pap smear **and at least one** preventive check is taken by a practice nurse on behalf of the medical practitioner.

M.2.22 Item 10995 can be claimed by a medical practitioner (not including a specialist or consultant physician) where a Pap smear **and at least one** preventive check is taken by a practice nurse on behalf of the medical practitioner **and** the patient is a woman, between the ages of 20 and 69 inclusive, who has not had a Pap smear in the last 4 years.

M.2.23 Items 10994 and 10995 include a Pap smear and preventive checks associated with women's sexual and reproductive health, which would routinely be undertaken in conjunction with a Pap smear. A preventive check is a service which is reasonably necessary and appropriate for preventive care based on evidence of effectiveness and efficacy appropriate to the age of the patient.

M.2.24 Services for items 10994 and 10995 must include a Pap smear and at least one preventive check from the following:

- Checks for sexually transmitted infections (including chlamydia)
- Taking of a sexual and reproductive history
- Advice on contraception
- Breast awareness education
- Advice on post natal issues
- Continence advice and education;

and may also include:

- Smoking, Nutrition, Alcohol and Physical Activity (SNAP) behavioural risk factor assessment
- Blood pressure measurement.

M.2.25 General practices are referred to the Royal Australian College of General Practitioners' (RACGP) *Guidelines for preventive activities in general practice – 6th edition* (Red Book), the RACGP (2004) *SNAP guide: a population health guide to behavioural risk factors in general practice* and National Aboriginal Community Controlled Health Organisations (NACCHO) 2005 *National Guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples* for recommendations on appropriate checks for women in particular age ranges.

M.2.26 Where, in the course of discussion of sexual history and current sexual activity, a practice nurse becomes aware that one of the checks listed for another age group is appropriate, the practice nurse may include that check as part of the service provided.

M.2.27 Patients with symptoms should be referred to their GP for diagnosis and management.

M.2.28 Items 10994 and 10995 cannot be claimed together or in conjunction with items 10998, 10999, 2497-2509 or 2598-2616.

M.2.29 Items 10998 and 10999 apply to the taking of a Pap smear only.

M.2.30 Item 10998 can 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.

M.2.31 Item 10999 can 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 **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.2.32 Where the medical practitioner claims item 10995 or 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 be available. This incentive will be paid to the medical practitioner claiming item 10995 or 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 Medicare Australia PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip

M.2.33 Items 10998 and 10999 cannot be claimed in conjunction with each other or with items 10994, 10995, 2497- 2509 or 2598 - 2616.

M.2.34 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.2.35 The practice nurse must be appropriately qualified and trained to take cervical smears and other preventive checks. 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 and other preventive checks should have undertaken an accredited training course.

M.2.36 Continuing professional development is a compulsory part of the credentialling arrangements and is recommended for all nurses taking Pap smears and providing preventive checks in jurisdictions where there are currently no credentialling arrangements.

M.2.37 General practices, where nurses take Pap smears and provide preventive checks, should also have a written clinical risk management strategy covering issues like clinical roles, pathology follow-up and patient consent.

M.2.38 In all cases, the medical practitioner under whose supervision the Pap smear and preventive checks are provided 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 perform Pap smears and other preventive checks. Medical practitioners are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

M.2.39 The supervising medical practitioner and practice nurse must also comply with any relevant legislative or regulatory requirements, including those applying to state and territory cervical cytology registers or laboratories and disease notification registers.

M.2.40 The medical practitioner is not required to be present while the Pap smear and preventive checks are undertaken. It is up to the medical practitioner to decide whether they need to see the patient. Where the medical practitioner has a consultation with the patient, then the medical practitioner is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse is itemised separately under item 10994, 10995, 10998 or 10999 (as applicable) and should not be counted as part of the Medicare item claimed for time spent with the medical practitioner.

M.2.41 All GPs whether vocationally registered or not are eligible to claim these items.

M.2.42 Item 10990 or 10991 can be claimed in conjunction with item 10994, 10995, 10998 or 10999 provided the conditions of item 10990 or 10991 are satisfied (see explanatory note M.1).

M.3 ALLIED HEALTH SERVICES (ITEMS 10950 TO 10970)

M.3.1 Overview of the Medicare Allied Health and Dental Care Initiative

Medicare Allied Health and Dental Care Initiative

The Medicare Allied Health and Dental Care initiative commenced on 1 July 2004. It provides for Medicare benefits to be paid for certain services provided by eligible allied health professionals, dentists and dental specialists to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan. The term 'GP' is used in this section as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician) able to refer patients for eligible allied health and dental care services.

EPC plan

The term 'EPC plan' is a generic one. Patients are considered to be managed under an EPC plan, if during the last two years:

- their GP has prepared an EPC plan for them and claimed:
 - MBS items 721 and 723 together – Chronic Disease Management (CDM) items for the preparation of a GP Management Plan (GPMP) and coordination of Team Care Arrangements (TCA); or
 - MBS item 720 – preparation of an EPC multidisciplinary care plan; or
 - MBS item 722 – preparation of an EPC multidisciplinary discharge care plan; or
- their GP has contributed to a plan prepared for them as a resident of an aged care facility and claimed item 730 or 731; or
- their GP has reviewed their existing EPC plan and claimed MBS item 724, 725 or 727.

For more information on the Chronic Disease Management items, refer to the explanatory notes for these items.

Before a rebate can be paid for the allied health service on referral from a GP, either the patient must have already claimed a rebate for the relevant EPC planning item/s, or the GP must have lodged a direct bill (bulk billing) claim with Medicare Australia for the relevant EPC planning item/s and received payment for that claim from Medicare Australia.

M.3.2 ALLIED HEALTH SERVICES ATTRACTING MEDICARE BENEFITS

Eligible allied health services

The following groups of allied health professionals are eligible to provide services under the Medicare Allied Health and Dental Care initiative. Allied health professionals must meet the provider eligibility requirements set out below (at M.3.4) and be registered with Medicare Australia.

- Aboriginal health workers
- Audiologists
- Chiropodists
- Chiropractors
- Diabetes Educators
- Dietitians
- Exercise Physiologists
- Mental health workers
- Occupational Therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Speech Pathologists

Number of services per year

Medicare benefits are available for up to five (5) allied health services per eligible patient, per calendar year. The Medicare rebate for each allied health service is \$46.80.

The five allied health services can be made up of one type of service (eg five physiotherapy services) or a combination of different types of services (eg one dietetic and four podiatry services).

In addition, people whose dental problems are exacerbating their chronic condition, may be eligible to receive a Medicare rebate for up to three (3) eligible dental care services per calendar year. There are separate explanatory notes for the dental care items at M.4.

Out-of-pocket expenses and Medicare Safety Net

Allied health professionals are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Allied health services in excess of five (5) in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

The allied health items only apply to patients with chronic conditions and complex care needs being managed under an EPC plan (described above), and where the patient is referred to an eligible allied health professional by their GP. The allied health services must be recommended in the patient's EPC plan as part of the management of their chronic and complex condition.

A chronic medical condition is one that has been or is likely to be present for at least six (6) months including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, mental disorders, arthritis and musculoskeletal conditions. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP and at least two (2) other health or care providers.

Allied health professionals providing the service may be part of the EPC planning team convened by the GP to manage a patient's chronic and complex condition. However, the service may also be provided by an allied health professional who is not part of the EPC planning team, where the service has been identified as necessary by the patient's GP.

Checking patient eligibility for allied health services

Patients seeking Medicare rebates for allied health services will need to have an *EPC program referral form for allied health services under Medicare* signed by their GP. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether there is an EPC plan in place and the number of allied health services already claimed by the patient during the calendar year. Allied health professionals or the patient can call Medicare Australia on 132 011 to check this information.

Publicly funded services

The allied health items (10950-10970) 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.

However, 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 Government health clinic, items 10950-10970 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the Service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Medicare Australia. These services must also be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

M.3.3 REFERRAL REQUIREMENTS (GPs TO ALLIED HEALTH PROFESSIONALS)

Referral form

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using an *EPC program referral form for allied health services under Medicare* (the referral form). GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

GPs may use one referral form to refer patients for single or multiple services of the same service type (eg five chiropractic services). If referring a patient for single or multiple services of different service types (eg two dietetic services and three podiatry services), a separate referral form will be needed for each service type.

The patient will need to present the referral form to the allied health professional at the first consultation, unless the GP has previously provided it directly to the allied health professional.

Allied health professionals are required to retain the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

A copy of the referral form is **not** required to accompany Medicare claims, and allied health professionals do not need to attach a signed copy of the form to patients' itemised accounts/receipts or assignment of benefit forms.

The referral form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120. GPs may modify the relevant referral form to suit their practice needs (for example, relevant software packages) as long as the information contained therein is substantially retained.

Referral validity

Medicare benefits are available for up to five (5) allied health services per patient per calendar year. If a patient has not used all of their allied health services under a referral in a calendar year, it is not necessary to obtain a new referral for the 'unused' services. However, for the purposes of Medicare benefits, any services received from 1 January of the following year will count as part of the total of five services for which the patient is eligible in that calendar year.

When patients have used all of their referred services, or require a referral for a different type of allied health service recommended in their EPC plan, they will need to obtain a new referral from their GP. GPs may choose to use this visit to undertake a review of the patient's EPC plan or, where appropriate, to manage the process using a GP consultation item.

It is not necessary to have a new EPC plan prepared each calendar year in order to access a new referral(s) for eligible allied health services. Patients continue to be eligible for rebates for allied health services while they are being managed under an EPC plan as long as the need for eligible services continues to be recommended in their plan.

M.3.4 ALLIED HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

The allied health items can only be claimed for services provided by: Aboriginal health workers; audiologists; diabetes educators; dietitians; exercise physiologists; mental health workers; occupational therapists; physiotherapists; podiatrists; chiropractors; chiropractors; osteopaths; psychologists; and speech pathologists, who are registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, an allied health professional 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.

Specific eligibility requirements

Specific eligibility requirements for allied health professionals providing services under these items are as follows:

Aboriginal Health Workers practising in the Northern Territory must be registered with the Aboriginal Health Workers Board of the NT; in other States and the Australian Capital Territory they must have been awarded a Certificate Level III (or higher) in Aboriginal and Torres Strait Islander Health from a Registered Training Organisation that meets training standards of the Australian National Training Authority's Australian Quality Training Framework.

Audiologists must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member – Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Diabetes Educators must be a Credentialed Diabetes Educator (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).

Chiropractors must be registered with the Chiropractors (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Exercise Physiologists must be an 'Accredited Exercise Physiologist' as accredited by the Australian Association for Exercise and Sports Science (AAESS).

Mental Health Workers

'Mental health' can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following:

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers; and
- Aboriginal health workers.

Psychologists, occupational therapists and Aboriginal health workers are eligible in separate categories for these items.

A **mental health nurse** may qualify if they are –

- a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or

- a 'Credentialled Mental Health Nurse' as certified by the Australian and New Zealand College of Mental Health Nurses (ANZCMHN), if providing mental health services in other States or the Northern Territory.

A **social worker** must be a 'Member' of the Australian Association of Social Workers (AASW) and be certified by AASW as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999'.

Occupational therapists in Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising; in other States and the Australian Capital Territory, they must be a 'Full-time Member' or 'Part-time Member' of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.

Osteopaths must be registered with the Osteopaths (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Physiotherapists must be registered with the Physiotherapists Registration Board in the State or Territory in which they are practising.

Podiatrists/Chiropodists in all States and the Australian Capital Territory must be registered with the Podiatrists Registration Board in the State or Territory in which they are practising. If practising in the Northern Territory, Podiatrists/Chiropodists must be registered with the Podiatrists Registration Board in any other State or the Australian Capital Territory, or be a "Full Member" of the Australian Podiatry Association (ApodA) in any other State or the Australian Capital Territory.

Psychologists must be registered with the Psychologists Registration Board in the State or Territory in which they are practising.

Speech Pathologists in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a 'Practising Member' of Speech Pathology Australia.

A copy of these eligibility requirements may be obtained from Medicare Australia by calling 132 150 or at www.medicareaustralia.gov.au or www.health.gov.au/epc.

Registering with Medicare Australia

Provider registration forms may be obtained from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au.

Chiropractors, osteopaths, physiotherapists and podiatrists who were already registered with Medicare Australia on 1 July 2004 to order diagnostic imaging under Medicare, do not need to re-register to provide services under this initiative. Allied health professionals registering with Medicare Australia for the first time only need to fill in one application form which will give them rights to provide services under this initiative and order diagnostic imaging tests etc., where appropriate, under Medicare.

M.3.5 ADDITIONAL REQUIREMENTS OF THE ALLIED HEALTH SERVICE

Service length and type

Services provided by eligible allied health professionals under the allied health items must be of at least 20 minutes duration and provided to an individual patient, not to a group. The allied health professional must personally attend the patient.

Reporting back to the GP

Where an allied health professional provides a single service to the patient under a referral, they must provide a written report back to the referring GP after that service.

Where an allied health professional provides multiple services to the same patient under the one referral, they must provide a written report back to the referring GP after the first and last service only, or more often if clinically necessary. Written reports should include:

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

M.3.6 FURTHER INFORMATION

Further information about Medicare Benefits Schedule items, is available on the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Medicare Australia provider inquiry line on 132 150.

M.4 DENTAL CARE SERVICES (ITEMS 10975 TO 10977)

M.4.1 Overview of the Medicare Allied Health and Dental Care Initiative

Medicare Allied Health and Dental Care Initiative

The Medicare Allied Health and Dental Care initiative commenced on 1 July 2004. It provides for Medicare benefits to be paid for certain services provided by eligible allied health professionals, dentists and dental specialists to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan. The term

'GP' is used in this section as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician) able to refer patients for eligible allied health and dental care services.

EPC plan

The term 'EPC plan' is a generic one. Patients are considered to be managed under an EPC plan, if during the last two years:

- their GP has prepared an EPC plan for them and claimed:
 - MBS items 721 and 723 together – Chronic Disease Management (CDM) items for the preparation of a GP Management Plan (GPMP) and coordination of Team Care Arrangements (TCA); or
 - MBS item 720 – preparation of an EPC multidisciplinary care plan; or
 - MBS item 722 – preparation of an EPC multidisciplinary discharge care plan; or
- their GP has contributed to a plan prepared for them as a resident of an aged care facility and claimed item 730 or 731; or
- their GP has reviewed their existing EPC plan and claimed MBS item 724, 725 or 727.

For more information on the Chronic Disease Management items, refer to the explanatory notes for these items.

Before a rebate can be paid for the dental care service on referral from a GP, either the patient must have already claimed a rebate for the relevant EPC planning item/s, or the GP must have lodged a direct bill (bulk billing) claim with Medicare Australia for the relevant EPC planning item/s and received payment for that claim from Medicare Australia.

M.4.2 DENTAL SERVICES ATTRACTING MEDICARE BENEFITS

Number of services per year

Medicare benefits are available for up to three (3) dental care services per eligible patient, per calendar year. The Medicare rebate for each dental service is \$77.95.

Out-of-pocket expenses and Medicare Safety Net

Dentists and dental specialists are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit for the dental care items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Dental services in excess of three (3) in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

The dental items only apply to patients being managed under an EPC plan (described above) and where the patient is referred to an eligible dental practitioner (dentist) by their GP for a dental condition that is exacerbating the patient's chronic and complex medical condition.

The dental care services provided must be services recommended in the patient's EPC plan as part of the management of their chronic and complex condition.

How the dental items are to be used

There are three dental care items:

- 10975 (dental assessment by an eligible dentist)
- 10976 (dental treatment by an eligible dentist)
- 10977 (dental assessment or treatment by an eligible dentist or eligible dental specialist, on referral from an eligible dentist).

Specific requirements in relation to each of these items are set out below (see note M.4.5)

The dental care services may be provided in the following combinations:

- A dental assessment (1 x item 10975) AND two dental treatments (2 x item 10976) provided by an eligible dentist; or
- A dental assessment (1 x item 10975) AND one dental treatment (1 x item 10976) provided by an eligible dentist AND one dental assessment or treatment (1 x item 10977) provided by another eligible dentist or dental specialist; or
- A dental assessment (1 x item 10975) provided by an eligible dentist AND two dental assessments or treatments (2 x item 10977) provided by another eligible dentist or dental specialist.

When a patient is first referred to a dentist under an EPC plan, the patient must receive a dental assessment (item 10975) as their first service. After the first year, these services may include a combination of one dental assessment (item 10975) and two other dental care items (10976 or 10977) in any order.

For example:

- If a GP identifies a need for dental care as part of a patient's EPC plan and refers the patient to an eligible dentist in June 2007, the patient must receive a dental assessment as their first service, and may claim a Medicare benefit for that service and for two (2) subsequent dental treatment services (see combinations above) during the remainder of the 2007 calendar year.
- Where the patient is referred to an eligible dentist during the following calendar year (2008), they may claim a Medicare benefit for two (2) dental treatment services and a subsequent dental assessment. That is, as long as the patient has a dental assessment as their first treatment under an EPC plan, they may choose the order in which they access eligible services each successive calendar year, as long as sometime during that year, they have a dental assessment.

Checking patient eligibility for dental services

Patients seeking Medicare rebates for dental services will need to have an *EPC program referral form for dental care services under Medicare* signed by their GP. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether there is an EPC plan in place and the number of dental services already claimed by the patient during the calendar year. Dentists and dental specialists or the patient can call Medicare Australia on 132 011 to check this information.

Supply of prostheses

The cost of making/supplying prostheses such as, an inlay, crown, bridge, implant, denture, obturator, veneer or a combination of these are **NOT** covered by Medicare. Dentists and dental specialists should separately itemise any costs associated with the supply/making of prostheses when billing patients for a dental treatment (and not include these costs under the Medicare dental care items). Costs associated with fitting prostheses can be included under items 10976 or 10977.

Publicly funded dental services

The dental items (10975-10977) 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.

However, 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 Government health clinic, items 10975-10977 can be claimed for services provided by eligible dentists and dental specialists salaried by, or contracted to, the Service or health clinic. All requirements of the relevant item must be met, including registration of the dentist or dental specialist with Medicare Australia. These services must also be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

M.4.3 REFERRAL REQUIREMENTS (FROM GPs TO DENTISTS)

Referral forms

For Medicare benefits to be payable, the patient must be referred to an eligible dentist by their GP using an *EPC program referral form for dental care services under Medicare* (the referral form). GPs are encouraged to attach a copy of the relevant part of the patient's EPC plan to the referral form.

The dentist/ dental specialist must be in receipt of the referral at the first dental care consultation. Dentist/dental specialists are required to retain the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

A copy of the referral form is **not** required to accompany Medicare claims and dentists/dental specialists do not need to attach a signed copy of the form to patients' itemised accounts/receipts and assignment of benefit forms.

The referral form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120. GPs may modify the relevant referral form to suit their practice needs (for example, relevant software packages) as long as the information contained therein is substantially retained.

Referral validity

The referral form is valid for three eligible services. If all three of these services are not accessed during the calendar year in which the patient is referred, the referral may be used in the next calendar year. However, the services will be counted as part of the three (3) rebates for dental care services available to the patient during that calendar year (that is, the patient may only claim up to three (3) rebates in total each year).

Subsequent referrals

Where patients wish to access Medicare benefits for eligible dental care services during their next period of eligibility for rebates (that is, the next calendar year), and their referral form is no longer valid (that is, they have already accessed the three services covered by that form) they should see their GP to obtain a new referral. Depending on the patient's circumstances and needs, GPs may choose to use this visit to undertake a review of the patient's EPC plan or, where appropriate, to manage the process using a GP consultation item.

It is not necessary to have a new EPC plan prepared every calendar year in order to access a new referral(s) for eligible dental care services. Patients continue to be eligible for rebates for dental services while they are being managed under an EPC plan.

M.4.4 DENTIST AND DENTAL SPECIALIST ELIGIBILITY

Eligibility requirements

Eligible dentists and dental specialists are those recognised professionals who are registered under relevant State or Territory law, and who are also registered with Medicare Australia to provide dental care services under the Medicare Allied Health and Dental Care initiative.

Registering with Medicare Australia

Dentists and dental specialists who are registered with Medicare Australia to order diagnostic imaging or pathology tests, for prescribing, or for specialist referral under Medicare, are also eligible to provide services under this initiative using their current Medicare provider number. Dentists and dental specialists registering with Medicare Australia for the first time only need to fill in one application form which will give them rights to provide services under this initiative and order diagnostic imaging or pathology tests etc., under Medicare.

Provider registration forms may be obtained from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au.

M.4.5 ADDITIONAL REQUIREMENTS OF THE DENTAL SERVICE

Dental assessment (item 10975) and written report

This item can only be provided on referral from a GP for a patient being managed under an EPC plan. It MUST be claimed first for all eligible patients in order for items 10976 and 10977 to be provided under a dental care plan, and then as one of the three items each calendar year where further care is being provided.

The item should not be claimed more than once per calendar year unless the condition of the patient has changed substantially. Where the patient's condition requires an additional assessment to be provided within the calendar year, the patient's invoice or Medicare voucher should be annotated to indicate this.

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 oral hygiene problems (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 dental assessment means a comprehensive assessment of a patient's dental health, and whether further dental treatment should be offered to the patient.

The assessment should include:

- (a) an evaluation of all teeth, their supporting tissues and the oral tissues; and
- (b) a written report provided to the referring GP.

The written report 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.

The written report of the assessment should be provided to the referring GP and a copy should also be offered to the patient. Where the patient has a carer, a copy of the report (or relevant extracts) should be offered to the carer, with the patient's agreement.

The dental assessment item may include referral for other services attracting a Medicare benefit from MBS item category 5 (diagnostic imaging) or category 6 (pathology) services where clinically relevant, but should not take the form of a health screening service. These diagnostic and pathology services do not count towards the three (3) annual dental visits available under the Medicare Allied Health and Dental Care initiative.

Dentists can provide services under item 10976 on the same day as a dental assessment if clinically indicated. These services will count as two (2) of the three (3) annual visits available under the Medicare Allied Health and Dental Care initiative.

Dental treatment (item 10976)

Services provided under item 10976 may only be provided where the patient has been the recipient of a dental assessment (item 10975). (Note: Item 10975 MUST be claimed first for all eligible patients in order for item 10976 to be provided under a dental care plan, and then each calendar year where further dental care is being provided).

This item only applies to services provided that will improve or relieve the dental condition that is exacerbating the chronic and complex medical condition for which the EPC plan has been formed.

Some services that would be appropriate under this item may be - but **are not** restricted to:

- (a) Tooth extraction and oral surgery;
- (b) Treatment of acute periodontal infection;
- (c) Restorative services, such as metallic or adhesive restorations, or capping;
- (d) Root planning and subgingival curettage;
- (e) Endodontics; and
- (f) Drainage of abscesses or cysts.

Dental assessment or treatment by a registered dentist or dental specialist on referral from another dentist (item 10977)

Services provided under item 10977 may only be provided where the patient has been the recipient of a dental assessment (item 10975), where the dentist providing the service under item 10975 determined that further assessment and treatment from a dental specialist or another dentist was required. (Note: Item 10975 MUST be claimed first for all eligible patients in order for item 10977 to be provided under a dental care plan, and then each calendar year where further dental care is being provided).

A written report of the assessment must also be sent to the referring dentist as well as the original referring GP.

Dental specialist for the purposes of item 10977

A dental specialist is a person who is:

- (a) registered or licensed as a periodontist, endodontist, pedodontist, or orthodontist under a law of a State or Territory; or
- (b) registered or licensed as a dental specialist under a law of a State or Territory and recognised by the registering or licensing authority as a person who practices in the speciality of periodontics, endodontics, pedodontics, or orthodontics.

For the purposes of item 10977, 'dentist or dental specialist' includes all registered dental specialists as well as registered dentists who restrict their practice to 'special needs' dentistry.

M.4.6 FURTHER INFORMATION

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline. A copy of the Medicare Allied Health and Dental Care Supplement can be accessed from this site. The Supplement includes more information about Medicare, including how to make a claim from Medicare.

Further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

M.5 Services provided by a registered Aboriginal Health Worker on behalf of a medical practitioner. Immunisation services provided by a registered Aboriginal Health Worker (item 10988)

M.5.1 Item 10988 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 registered Aboriginal Health Worker on behalf of the medical practitioner.

M.5.2 Item 10988 can be claimed only once per patient visit, even if more than one vaccine is administered during the same patient visit.

M.5.3 A registered Aboriginal Health Worker means an Aboriginal Health Worker in the Northern Territory registered under the *Health Practitioners Act 2004 (NT)*, who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

M.5.4 The registered Aboriginal Health Worker must be appropriately qualified and trained to provide immunisations. This includes compliance with any territory requirements.

M.5.5 The medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the patient.

M.5.6 Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the registered Aboriginal Health Worker, but should be able to be contacted for advice if required.

M.5.7 The immunisation must be performed by the registered Aboriginal Health Worker in accordance with the current edition of the Australian Immunisation Handbook and the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.

M.5.8 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.5.9 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 current edition of the Australian Immunisation Handbook. 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 territory limitations on the administration of some vaccines, such as those for tuberculosis, yellow fever and Q-fever.

M.5.10 All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by the Northern Territory Department of Health and Community Services are also eligible to claim this item.

M.5.11 Where the medical practitioner provides a professional attendance to the patient (in addition to the immunisation service provided by the registered Aboriginal Health Worker), the medical practitioner may also claim for the professional attendance they provide to the patient.

M.5.12 Item 10991 can also be claimed in conjunction with item 10988 provided the conditions of both items are satisfied (see explanatory note M.1).

Wound management services provided by a registered Aboriginal Health Worker (item 10989)

M.5.13 Item 10989 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 registered Aboriginal Health Worker on behalf of the medical practitioner.

M.5.14 Item 10989 can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.

M.5.15 A registered Aboriginal Health Worker means an Aboriginal Health Worker in the Northern Territory registered under the *Health Practitioners Act 2004 (NT)*, who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

M.5.16 The registered Aboriginal Health Worker must be appropriately qualified and trained to treat wounds. This includes compliance with any territory requirements.

M.5.17 The medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient.

M.5.18 Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the registered Aboriginal Health Worker, but should be able to be contacted for advice if required.

M.5.19 The medical practitioner must conduct an initial assessment of the patient (including under a distance supervision arrangement if the medical practitioner is not physically present) in order to give instruction in relation to the treatment of the wound.

M.5.20 Where a registered Aboriginal Health Worker provides ongoing wound management, the medical practitioner is not required to give instruction or see the patient during each subsequent visit.

M.5.21 The wound management must be performed by the registered Aboriginal Health Worker in accordance with the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.

M.5.22 All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by the Northern Territory Department of Health and Community Services are also eligible to claim this item.

M.5.23 Where the medical practitioner provides a professional attendance to the patient (in addition to the wound management service provided by the registered Aboriginal Health Worker), the medical practitioner may also claim for the professional attendance they provide to the patient.

M.5.24 Item 10991 can also be claimed in conjunction with item 10989 provided the conditions of both items are satisfied (see explanatory note M.1).

GROUP M3 - ALLIED HEALTH SERVICES

10950	<p>Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker if:</p> <p>(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</p> <p>(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</p> <p>(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 substantially complies with the form issued by the Department; and</p> <p>(d) the person is not an admitted patient of a hospital or day-hospital facility; and</p> <p>(e) the service is provided to the person individually and in person; and</p> <p>(f) the service is of at least 20 minutes duration; and</p> <p>(g) after the service, the eligible Aboriginal health worker gives a written report to the referring medical practitioner mentioned in paragraph (c):</p> <p style="padding-left: 20px;">(i) if the service is the only service under the referral - in relation to that service; or</p> <p style="padding-left: 20px;">(ii) if the service is the first or the last service under the referral - in relation to that service; or</p> <p style="padding-left: 20px;">(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</p> <p>(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;</p> <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year (See para M.3 of explanatory notes to this Category)</p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>
10951	<p>Diabetes education health service provided to a person by an eligible diabetes educator if:</p> <p>(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</p> <p>(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</p> <p>(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 substantially complies with the form issued by the Department; and</p> <p>(d) the person is not an admitted patient of a hospital or day-hospital facility; and</p> <p>(e) the service is provided to the person individually and in person; and</p> <p>(f) the service is of at least 20 minutes duration; and</p> <p>(g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c):</p> <p style="padding-left: 20px;">(i) if the service is the only service under the referral - in relation to that service; or</p> <p style="padding-left: 20px;">(ii) if the service is the first or the last service under the referral - in relation to that service; or</p> <p style="padding-left: 20px;">(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</p> <p>(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;</p> <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year (See para M.3 of explanatory notes to this Category)</p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>

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<p>10952</p>	<p>Audiology health service provided to a person by an eligible audiologist if:</p> <ul style="list-style-type: none"> (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 substantially 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): <ul style="list-style-type: none"> (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; <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <i>(See para M.3 of explanatory notes to this Category)</i></p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>
<p>10953</p>	<p>Exercise physiology service provided to a person by an eligible exercise physiologist if:</p> <ul style="list-style-type: none"> (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 exercise physiologist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially 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 exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c): <ul style="list-style-type: none"> (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; <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <i>(See para M.3 of explanatory notes to this Category)</i></p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>

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<p>10954</p>	<p>Dietetics health service provided to a person by an eligible dietitian if:</p> <ul style="list-style-type: none"> (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 substantially 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): <ul style="list-style-type: none"> (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; <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <i>(See para M.3 of explanatory notes to this Category)</i></p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>
<p>10956</p>	<p>Mental health service provided to a person by an eligible mental health worker if:</p> <ul style="list-style-type: none"> (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 substantially 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): <ul style="list-style-type: none"> (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; <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <i>(See para M.3 of explanatory notes to this Category)</i></p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>

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<p>10958</p>	<p>Occupational therapy health service provided to a person by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (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 substantially 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): <ul style="list-style-type: none"> (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; <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a 12 calendar year <i>(See para M.3 of explanatory notes to this Category)</i></p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>
<p>10960</p>	<p>Physiotherapy health service provided to a person by an eligible physiotherapist if:</p> <ul style="list-style-type: none"> (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 substantially 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): <ul style="list-style-type: none"> (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; <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <i>(See para M.3 of explanatory notes to this Category)</i></p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>

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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 substantially 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;

- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year
(See para M.3 of explanatory notes to this Category)
Fee: \$55.05 **Benefit:** 85% = \$46.80

10962

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 substantially 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;

- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year
(See para M.3 of explanatory notes to this Category)
Fee: \$55.05 **Benefit:** 85% = \$46.80

10964

MISCELLANEOUS

MISCELLANEOUS

<p>10966</p>	<p>Osteopathy health service provided to a person by an eligible osteopath if:</p> <ul style="list-style-type: none"> (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 substantially 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): <ul style="list-style-type: none"> (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; <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <i>(See para M.3 of explanatory notes to this Category)</i></p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>
<p>10968</p>	<p>Psychology health service provided to a person by an eligible psychologist if:</p> <ul style="list-style-type: none"> (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 substantially 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): <ul style="list-style-type: none"> (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; <p>- to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <i>(See para M.3 of explanatory notes to this Category)</i></p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>

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 substantially 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 calendar year
(See para M.3 of explanatory notes to this Category)

10970

Fee: \$55.05 **Benefit:** 85% = \$46.80

GROUP M4 - DENTAL SERVICES

<p>10975</p>	<p>Dental assessment provided to a person by an eligible dental practitioner if:</p> <ul style="list-style-type: none"> (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 substantially 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; <p>- to a maximum of 3 services (including any services to which this item or item 10976 or 10977 applies) in a calendar year <i>(See para M.4 of explanatory notes to this Category)</i></p> <p>Fee: \$91.70 Benefit: 85% = \$77.95</p>
<p>10976</p>	<p>Dental treatment provided to a person by an eligible dental practitioner if:</p> <ul style="list-style-type: none"> (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 substantially 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; <p>- to a maximum of 3 services (including any services to which this item or item 10975 or 10977 applies) in a calendar year <i>(See para M.4 of explanatory notes to this Category)</i></p> <p>Fee: \$91.70 Benefit: 85% = \$77.95</p>
<p>10977</p>	<p>Dental service provided to a person by an eligible dental practitioner or an eligible dental specialist (the <i>providing dentist</i>) if:</p> <ul style="list-style-type: none"> (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 substantially 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; <p>- to a maximum of 3 services (including any services to which this item or item 10975 or 10976 applies) in a calendar year <i>(See para M.4 of explanatory notes to this Category)</i></p> <p>Fee: \$91.70 Benefit: 85% = \$77.95</p>

MISCELLANEOUS	MISCELLANEOUS
GROUP M5 - ABORIGINAL HEALTH WORKER	
10988	<p>Immunisation provided to a person by a registered Aboriginal Health Worker if:</p> <p>(a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital or approved day hospital facility</p> <p><i>(See para M.5 of explanatory notes to this Category)</i></p> <p>Fee: \$10.60 Benefit: 100% = \$10.60</p>
10989	<p>Treatment of a person's wound (other than normal aftercare) provided by a registered Aboriginal Health Worker if:</p> <p>(a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital or approved day hospital facility</p> <p><i>(See para M.5 of explanatory notes to this Category)</i></p> <p>Fee: \$10.60 Benefit: 100% = \$10.60</p>

GROUP M1 - MANAGEMENT OF BULK-BILLED SERVICES

10990	<p>A medical service to which an item in this table (other than this item or item 10991) applies if:</p> <ul style="list-style-type: none"> (a) the service is an unreferral 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: <ul style="list-style-type: none"> (i) this item; and (ii) the other item in this table applying to the service <p><i>(See para M.1 of explanatory notes to this Category)</i></p> <p>Fee: \$6.20 Benefit: 85% = \$5.30</p>
10991	<p>A medical service to which an item in this table (other than this item or item 10990) applies if:</p> <ul style="list-style-type: none"> (a) the service is an unreferral 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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) A geographical area included in any of the following SSD spatial units: <ul style="list-style-type: none"> (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) <p><i>(See para M.1 of explanatory notes to this Category)</i></p> <p>Fee: \$9.40 Benefit: 85% = \$8.00</p>

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 M.1 of explanatory notes to this Category)

10992

Fee: \$9.40 **Benefit:** 85% = \$8.00

GROUP M2 - SERVICES PROVIDED BY A PRACTICE NURSE ON BEHALF OF A MEDICAL PRACTITIONER	
10993	<p>Immunisation provided to a person by a practice nurse if:</p> <p>(a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner: and</p> <p>(b) the person is not an admitted patient of a hospital or approved day hospital facility</p> <p><i>(See para M.2 of explanatory notes to this Category)</i></p> <p>Fee: \$10.60 Benefit: 100% = \$10.60</p>
† 10994	<p>Services provided by a practice nurse, being the taking of a cervical smear and preventive checks, if:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital or approved day hospital facility.</p> <p>This item cannot be claimed with items 2497-2509, 2598-2616, 10995, 10998 or 10999.</p> <p><i>(See para M.2 of explanatory notes to this Category)</i></p> <p>Fee: \$21.25 Benefit: 100% = \$21.25</p>
† 10995	<p>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, and preventive checks if:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital or approved day hospital facility.</p> <p>This item cannot be claimed with items 2497-2509, 2598-2616, 10994, 10998 or 10999.</p> <p><i>(See para M.2 of explanatory notes to this Category)</i></p> <p>Fee: \$21.25 Benefit: 100% = \$21.25</p>
10996	<p>Treatment of a person's wound (other than normal aftercare) provided by a practice nurse if:</p> <p>(a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner: and</p> <p>(b) the person is not an admitted patient of a hospital or day-hospital facility</p> <p><i>(See para M.2 of explanatory notes to this Category)</i></p> <p>Fee: \$10.60 Benefit: 100% = \$10.60</p>
‡ 10998	<p>Service provided by a practice nurse, being the taking of a cervical smear from a person, if:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital or approved day hospital facility.</p> <p>This item cannot be claimed with items 2497-2509, 2598-2616, 10994, 10995 or 10999.</p> <p><i>(See para M.2 of explanatory notes to this Category)</i></p> <p>Fee: \$10.60 Benefit: 100% = \$10.60</p>
‡ 10999	<p>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:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital or approved day hospital facility.</p> <p>This item cannot be claimed with items 2497-2509 and 2598-2616, 10994, 10995 or 10998.</p> <p><i>(See para M.2 of explanatory notes to this Category)</i></p> <p>Fee: \$10.60 Benefit: 100% = \$10.60</p>

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 Electroencephalography (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 Electroencephalography (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 EEG 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/NZS 1269.3-2005; and
- (c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, AS IEC 60645.2-2002 and AS IEC 60645.3-2002.

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, non-isotonic fluids or powder 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.

DIAGNOSTIC	NEUROLOGY
GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	
SUBGROUP 1 - NEUROLOGY	
	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.)
11000	Fee: \$108.80 Benefit: 75% = \$81.60 85% = \$92.50
	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 <i>(See para D1.1 of explanatory notes to this Category)</i>
11003	Fee: \$287.85 Benefit: 75% = \$215.90 85% = \$244.70
	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 <i>(See para D1.2 of explanatory notes to this Category)</i>
11004	Fee: \$287.85 Benefit: 75% = \$215.90 85% = \$244.70
	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 <i>(See para D1.2 of explanatory notes to this Category)</i>
11005	Fee: \$287.85 Benefit: 75% = \$215.90 85% = \$244.70
	ELECTROENCEPHALOGRAPHY, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices
11006	Fee: \$147.60 Benefit: 75% = \$110.70 85% = \$125.50
	ELECTROCORTICOGRAPHY
11009	Fee: \$201.20 Benefit: 75% = \$150.90 85% = \$171.05
	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies) <i>(See para D1.3 of explanatory notes to this Category)</i>
11012	Fee: \$98.90 Benefit: 75% = \$74.20 85% = \$84.10
	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)
11015	Fee: \$132.45 Benefit: 75% = \$99.35 85% = \$112.60
	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)
11018	Fee: \$197.90 Benefit: 75% = \$148.45 85% = \$168.25
	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations
11021	Fee: \$132.45 Benefit: 75% = \$99.35 85% = \$112.60
	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 <i>(See para D1.4 and D1.8 of explanatory notes to this Category)</i>
11024	Fee: \$100.65 Benefit: 75% = \$75.50 85% = \$85.60
	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 <i>(See para D1.4 and D1.8 of explanatory notes to this Category)</i>
11027	Fee: \$149.20 Benefit: 75% = \$111.90 85% = \$126.85

DIAGNOSTIC	OPHTHALMOLOGY
SUBGROUP 2 - OPHTHALMOLOGY	
11200	PROVOCATIVE TEST OR TESTS FOR GLAUCOMA, including water drinking Fee: \$36.05 Benefit: 75% = \$27.05 85% = \$30.65
11203	TONOGRAPHY in the investigation or management of glaucoma, 1 or both eyes using an electrical tonography machine producing a directly recorded tracing Fee: \$60.90 Benefit: 75% = \$45.70 85% = \$51.80
11204	ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards <i>(See para D1.5 of explanatory notes to this Category)</i> Fee: \$95.65 Benefit: 75% = \$71.75 85% = \$81.35
11205	ELECTROOCULOGRAPHY of one or both eyes performed according to current professional guidelines or standards <i>(See para D1.5 of explanatory notes to this Category)</i> Fee: \$95.65 Benefit: 75% = \$71.75 85% = \$81.35
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 <i>(See para D1.5 of explanatory notes to this Category)</i> Fee: \$95.65 Benefit: 75% = \$71.75 85% = \$81.35
11211	DARK ADAPTOMETRY of one or both eyes with a quantitative (log cd/m ²) estimation of threshold in log lumens at 45 minutes of dark adaptations <i>(See para D1.5 of explanatory notes to this Category)</i> Fee: \$95.65 Benefit: 75% = \$71.75 85% = \$81.35
11212	OPTIC FUNDI, examination of, following intravenous dye injection Fee: \$61.95 Benefit: 75% = \$46.50 85% = \$52.70
11215	RETINAL PHOTOGRAPHY, multiple exposures of 1 eye with intravenous dye injection Fee: \$108.70 Benefit: 75% = \$81.55 85% = \$92.40
11218	RETINAL PHOTOGRAPHY, multiple exposures of both eyes with intravenous dye injection Fee: \$134.25 Benefit: 75% = \$100.70 85% = \$114.15
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, <u>bilateral</u> - to a maximum of 2 examinations (including examinations to which item 11224 applies) in any 12 month period <i>(See para D1.6 and D1.8 of explanatory notes to this Category)</i> Fee: \$59.90 Benefit: 75% = \$44.95 85% = \$50.95
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, <u>bilateral</u> , where it can be demonstrated that a further examination is indicated in the same 12 month period to which Item 11221 applies due to presence of one of the following conditions:- <ul style="list-style-type: none"> . 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 <i>(See para D1.6 and D1.7 and D1.8 of explanatory notes to this Category)</i> Fee: \$59.90 Benefit: 75% = \$44.95 85% = \$50.95
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, <u>unilateral</u> - to a maximum of 2 examinations (including examinations to which item 11221 applies) in any 12 month period <i>(See para D1.6 and D1.8 of explanatory notes to this Category)</i> Fee: \$36.10 Benefit: 75% = \$27.10 85% = \$30.70

DIAGNOSTIC	OTOLARYNGOLOGY
11225	<p>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, <u>unilateral</u>, <i>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:-</i></p> <ul style="list-style-type: none"> . 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 <p>- <i>each additional examination</i> (See para D1.6 and D1.7 and D1.8 of explanatory notes to this Category)</p> <p>Fee: \$36.10 Benefit: 75% = \$27.10 85% = \$30.70</p>
11235	<p>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</p> <p>Fee: \$108.45 Benefit: 75% = \$81.35 85% = \$92.20</p>
11237	<p>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</p> <p>Fee: \$71.95 Benefit: 75% = \$54.00 85% = \$61.20</p>
11240	<p>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)</p> <p>Fee: \$71.95 Benefit: 75% = \$54.00 85% = \$61.20</p>
11241	<p>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)</p> <p>Fee: \$91.60 Benefit: 75% = \$68.70 85% = \$77.90</p>
11242	<p>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)</p> <p>Fee: \$70.80 Benefit: 75% = \$53.10 85% = \$60.20</p>
11243	<p>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)</p> <p>Fee: \$70.80 Benefit: 75% = \$53.10 85% = \$60.20</p>
SUBGROUP 3 - OTOLARYNGOLOGY	
11300	<p>BRAIN stem evoked response audiometry (Anaes.) (See para D1.10 of explanatory notes to this Category)</p> <p>Fee: \$170.05 Benefit: 75% = \$127.55 85% = \$144.55</p>
11303	<p>ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears</p> <p>Fee: \$170.05 Benefit: 75% = \$127.55 85% = \$144.55</p>
11304	<p>ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears (See para D1.11 of explanatory notes to this Category)</p> <p>Fee: \$280.05 Benefit: 75% = \$210.05 85% = \$238.05</p>
11306	<p>Nondeterminate AUDIOMETRY (See para D1.12 of explanatory notes to this Category)</p> <p>Fee: \$19.40 Benefit: 75% = \$14.55 85% = \$16.50</p>
11309	<p>AUDIOGRAM, air conduction (See para D1.13 of explanatory notes to this Category)</p> <p>Fee: \$23.25 Benefit: 75% = \$17.45 85% = \$19.80</p>

DIAGNOSTIC	RESPIRATORY
11312	AUDIOGRAM, air and bone conduction or air conduction and speech discrimination (See para D1.13 of explanatory notes to this Category) Fee: \$32.85 Benefit: 75% = \$24.65 85% = \$27.95
11315	AUDIOGRAM, air and bone conduction and speech (See para D1.13 of explanatory notes to this Category) Fee: \$43.50 Benefit: 75% = \$32.65 85% = \$37.00
11318	AUDIOGRAM, air and bone conduction and speech, with other Cochlear tests (See para D1.13 of explanatory notes to this Category) Fee: \$53.65 Benefit: 75% = \$40.25 85% = \$45.65
11321	GLYCEROL INDUCED COCHLEAR FUNCTION CHANGES assessed by a minimum of 4 air conduction and speech discrimination tests (Klockoff's tests) (See para D1.13 of explanatory notes to this Category) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70
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: \$29.00 Benefit: 75% = \$21.75 85% = \$24.65
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: \$17.45 Benefit: 75% = \$13.10 85% = \$14.85
11330	IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner - 1 examination in any 4 week period Fee: \$7.00 Benefit: 75% = \$5.25 85% = \$5.95
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: \$51.70 Benefit: 75% = \$38.80 85% = \$43.95
11333	CALORIC TEST OF LABYRINTH OR LABYRINTHS Fee: \$39.40 Benefit: 75% = \$29.55 85% = \$33.50
11336	SIMULTANEOUS BITHERMAL CALORIC TEST OF LABYRINTHS Fee: \$39.40 Benefit: 75% = \$29.55 85% = \$33.50
11339	ELECTRONYSTAGMOGRAPHY Fee: \$39.40 Benefit: 75% = \$29.55 85% = \$33.50
SUBGROUP 4 - RESPIRATORY	
11500	BRONCHOSPIROMETRY, including gas analysis Fee: \$147.60 Benefit: 75% = \$110.70 85% = \$125.50

DIAGNOSTIC	VASCULAR
11503	<p>MEASUREMENT OF THE MECHANICAL OR GAS EXCHANGE FUNCTION OF THE RESPIRATORY SYSTEM, OR OF RESPIRATORY MUSCLE FUNCTION, OR OF VENTILATORY CONTROL MECHANISMS, using measurements of various parameters including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood, electrical activity of muscles (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed, not being a service associated with a service to which item 22018 applies (See para D1.15 of explanatory notes to this Category)</p> <p>Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15</p>
11506	<p>MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator - each occasion at which 1 or more such tests are performed</p> <p>Fee: \$18.10 Benefit: 75% = \$13.60 85% = \$15.40</p>
11509	<p>MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex respiratory function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed</p> <p>Fee: \$31.50 Benefit: 75% = \$23.65 85% = \$26.80</p>
11512	<p>CONTINUOUS MEASUREMENT OF THE RELATIONSHIP BETWEEN FLOW AND VOLUME DURING EXPIRATION OR INSPIRATION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex lung function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed</p> <p>Fee: \$54.55 Benefit: 75% = \$40.95 85% = \$46.40</p>
SUBGROUP 5 - VASCULAR	
11600	<p>BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - each day of monitoring for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies and where not performed in association with the administration of anaesthesia) (Anaes.)</p> <p>Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05</p>
11602	<p>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)</p> <p>Fee: \$51.00 Benefit: 75% = \$38.25 85% = \$43.35</p>
11604	<p>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)</p> <p>Fee: \$66.95 Benefit: 75% = \$50.25 85% = \$56.95</p>
11605	<p>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)</p> <p>Fee: \$66.95 Benefit: 75% = \$50.25 85% = \$56.95</p>
11610	<p>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)</p> <p>Fee: \$56.30 Benefit: 75% = \$42.25 85% = \$47.90</p>

DIAGNOSTIC	CARDIOVASCULAR
11611	<p>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)</p> <p>Fee: \$56.30 Benefit: 75% = \$42.25 85% = \$47.90</p>
11612	<p>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.</p> <p>Fee: \$99.30 Benefit: 75% = \$74.50 85% = \$84.45</p>
11614	<p>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)</p> <p>Fee: \$66.95 Benefit: 75% = \$50.25 85% = \$56.95</p>
11615	<p>MEASUREMENT OF DIGITAL TEMPERATURE, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing.</p> <p>Fee: \$67.05 Benefit: 75% = \$50.30 85% = \$57.00</p>
11627	<p>PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age</p> <p>Fee: \$202.05 Benefit: 75% = \$151.55 85% = \$171.75</p>
SUBGROUP 6 - CARDIOVASCULAR	
11700	<p>TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report (See para D1.18 of explanatory notes to this Category)</p> <p>Fee: \$27.60 Benefit: 75% = \$20.70 85% = \$23.50</p>
11701	<p>TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion (See para D1.19 of explanatory notes to this Category)</p> <p>Fee: \$13.75 Benefit: 75% = \$10.35 85% = \$11.70</p>
11702	<p>TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only</p> <p>Fee: \$13.75 Benefit: 75% = \$10.35 85% = \$11.70</p>
11708	<p>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)</p> <p>Fee: \$113.00 Benefit: 75% = \$84.75 85% = \$96.05</p>
11709	<p>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)</p> <p>Fee: \$148.00 Benefit: 75% = \$111.00 85% = \$125.80</p>
11710	<p>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</p> <p>Fee: \$45.85 Benefit: 75% = \$34.40 85% = \$39.00</p>
11711	<p>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</p> <p>Fee: \$24.95 Benefit: 75% = \$18.75 85% = \$21.25</p>

DIAGNOSTIC	GASTROENTEROLOGY & COLORECTAL
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: \$134.40 Benefit: 75% = \$100.80 85% = \$114.25
11713	SIGNAL AVERAGED ECG RECORDING involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician <i>(See para D1.21 of explanatory notes to this Category)</i> Fee: \$61.60 Benefit: 75% = \$46.20 85% = \$52.40
11715	BLOOD DYE DILUTION INDICATOR TEST Fee: \$106.75 Benefit: 75% = \$80.10 85% = \$90.75
11718	IMPLANTED PACEMAKER TESTING involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700 or 11721 applies Fee: \$30.70 Benefit: 75% = \$23.05 85% = \$26.10
11721	IMPLANTED PACEMAKER TESTING of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11700 or 11718 applies Fee: \$61.60 Benefit: 75% = \$46.20 85% = \$52.40
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: \$30.70 Benefit: 75% = \$23.05 85% = \$26.10
11724	UP-RIGHT TILT TABLE TESTING for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician - on premises equipped with a mechanical respirator and defibrillator Fee: \$149.20 Benefit: 75% = \$111.90 85% = \$126.85
† 11727	IMPLANTED DEFIBRILLATOR TESTING involving electrocardiography, assessment of pacing and sensing thresholds for pacing and defibrillation electrodes, download and interpretation of stored events and electrograms, including programming when required, not being a service associated with a service to which item 11700, 11718 or 11721 applies Fee: \$83.80 Benefit: 75% = \$62.85 85% = \$71.25
SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL	
11800	OESOPHAGEAL MOTILITY TEST, manometric Fee: \$154.20 Benefit: 75% = \$115.65 85% = \$131.10
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation Fee: \$154.20 Benefit: 75% = \$115.65 85% = \$131.10
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 <i>(See para D1.22 of explanatory notes to this Category)</i> Fee: \$1,801.90 Benefit: 75% = \$1,351.45 85% = \$1,738.00
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25

DIAGNOSTIC	GENITO/URINARY
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency Fee: \$220.70 Benefit: 75% = \$165.55 85% = \$187.60
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: \$24.35 Benefit: 75% = \$18.30 85% = \$20.70
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: \$98.20 Benefit: 75% = \$73.65 85% = \$83.50
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: \$98.20 Benefit: 75% = \$73.65 85% = \$83.50
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: \$145.85 Benefit: 75% = \$109.40 85% = \$124.00
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: \$145.85 Benefit: 75% = \$109.40 85% = \$124.00
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: \$145.85 Benefit: 75% = \$109.40 85% = \$124.00
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: \$378.45 Benefit: 75% = \$283.85 85% = \$321.70
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: \$378.45 Benefit: 75% = \$283.85 85% = \$321.70
11921	BLADDER WASHOUT TEST for localisation of urinary infection not including bacterial counts for organisms in specimens Fee: \$66.25 Benefit: 75% = \$49.70 85% = \$56.35
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: \$34.40 Benefit: 75% = \$25.80 85% = \$29.25
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: \$52.00 Benefit: 75% = \$39.00 85% = \$44.20
12012	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using less than the number of allergens included in a standard patch test battery <i>(See para D1.23 of explanatory notes to this Category)</i> Fee: \$18.35 Benefit: 75% = \$13.80 85% = \$15.60
12015	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery <i>(See para D1.23 of explanatory notes to this Category)</i> Fee: \$55.20 Benefit: 75% = \$41.40 85% = \$46.95

DIAGNOSTIC	OTHER
12018	<p>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)</p> <p>Fee: \$71.05 Benefit: 75% = \$53.30 85% = \$60.40</p>
12021	<p>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</p> <p>Fee: \$104.15 Benefit: 75% = \$78.15 85% = \$88.55</p>
SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	
12200	<p>COLLECTION OF SPECIMEN OF SWEAT by iontophoresis</p> <p>Fee: \$32.90 Benefit: 75% = \$24.70 85% = \$28.00</p>
12201	<p>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,</p> <p>for the detection of recurrent well-differentiated thyroid cancer in a patient who:</p> <p>(a) has had a total thyroidectomy and one ablative dose of radioactive iodine; and</p> <p>(b) is maintained on thyroid hormone therapy; and</p> <p>(c) is at risk of recurrence; and</p> <p>(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</p> <p style="padding-left: 40px;">(i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or</p> <p style="padding-left: 40px;">(ii) withdrawal is medically contraindicated because the patient has:</p> <p style="padding-left: 80px;">- unstable coronary artery disease; or</p> <p style="padding-left: 80px;">- hypopituitarism ; or</p> <p style="padding-left: 80px;">- a high risk of relapse or exacerbation of a previous severe psychiatric illness</p> <p>payable once only in any twelve month period. (See para D1.24 of explanatory notes to this Category)</p> <p>Fee: \$2,114.50 Benefit: 75% = \$1,585.90 85% = \$2,050.60</p>
12203	<p>OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE:</p> <p>a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed;</p> <p>b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner;</p> <p>c) the patient is referred by a medical practitioner;</p> <p>d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation;</p> <p>e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report ; and</p> <p>f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient</p> <p>- payable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period. (See para D1.25 of explanatory notes to this Category)</p> <p>Fee: \$519.60 Benefit: 75% = \$389.70 85% = \$455.70</p>

DIAGNOSTIC	OTHER
12207	<p>OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE:</p> <ol style="list-style-type: none"> 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; a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; the patient is referred by a medical practitioner; the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; 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 interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient <p><i>where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12203 applies</i> for the adjustment and/or testing of the effectiveness of a <i>positive pressure ventilatory support device</i> (other than nasal continuous positive airway pressure) in sleep, in a <i>patient with severe cardio-respiratory failure</i>, <u>and</u> 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)</p> <p>Fee: \$519.60 Benefit: 75% = \$389.70 85% = \$455.70</p>
12210	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED 0 - 12 YEARS, WHERE:</p> <ol style="list-style-type: none"> 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; a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; the patient is referred by a medical practitioner; the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; 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; the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. <p>payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. (See para D1.25 of explanatory notes to this Category)</p> <p>Fee: \$620.15 Benefit: 75% = \$465.15 85% = \$556.25</p>
12213	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED BETWEEN 12 AND 18 YEARS, WHERE:</p> <ol style="list-style-type: none"> 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; a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; the patient is referred by a medical practitioner; the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; 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; the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. <p>payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. (See para D1.25 of explanatory notes to this Category)</p> <p>Fee: \$558.70 Benefit: 75% = \$419.05 85% = \$494.80</p>

DIAGNOSTIC	OTHER
12215	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED 0 - 12 YEARS, WHERE:</p> <p>a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO₂ either end-tidal or transcutaneous, oxygen saturation and ECG are performed;</p> <p>b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner;</p> <p>c) the patient is referred by a medical practitioner;</p> <p>d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation;</p> <p>e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report;</p> <p>f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient.</p> <p>where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12210 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation. (See para D1.25 of explanatory notes to this Category)</p> <p>Fee: \$620.15 Benefit: 75% = \$465.15 85% = \$556.25</p>
12217	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED BETWEEN 12 AND 18 YEARS, WHERE:</p> <p>a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO₂ either end-tidal or transcutaneous, oxygen saturation and ECG are performed;</p> <p>b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner;</p> <p>c) the patient is referred by a medical practitioner;</p> <p>d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation;</p> <p>e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report;</p> <p>f) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient.</p> <p>where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12213 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation. (See para D1.25 of explanatory notes to this Category)</p> <p>Fee: \$558.70 Benefit: 75% = \$419.05 85% = \$494.80</p>
12306	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for:</p> <ul style="list-style-type: none"> . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. <p>Measurement of 2 or more sites - 1 service only in a period of 24 months - including interpretation and report; not being a service associated with a service to which item 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) (See para D1.26 of explanatory notes to this Category)</p> <p>Fee: \$90.45 Benefit: 75% = \$67.85 85% = \$76.90</p>
12309	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using quantitative computerised tomography, for:</p> <ul style="list-style-type: none"> . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. <p>Measurement of 2 or more sites - 1 service only in a period of 24 months - including interpretation and report; not being a service associated with a service to which item 12306, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) (See para D1.26 of explanatory notes to this Category)</p> <p>Fee: \$90.45 Benefit: 75% = \$67.85 85% = \$76.90</p>

DIAGNOSTIC	OTHER
12312	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions:</p> <ul style="list-style-type: none"> . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; or . female hypogonadism lasting more than 6 months before the age of 45. <p>Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 12 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12315, 12318 or 12321 applies (Ministerial Determination) (See para D1.26 of explanatory notes to this Category)</p> <p>Fee: \$90.45 Benefit: 75% = \$67.85 85% = \$76.90</p>
12315	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions:</p> <ul style="list-style-type: none"> . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. <p>Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 24 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12318 or 12321 applies (Ministerial Determination) (See para D1.26 of explanatory notes to this Category)</p> <p>Fee: \$90.45 Benefit: 75% = \$67.85 85% = \$76.90</p>
12318	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using quantitative computerised tomography, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions:</p> <ul style="list-style-type: none"> . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; . female hypogonadism lasting more than 6 months before the age of 45; . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. <p>Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 24 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12321 applies (Ministerial Determination) (See para D1.26 of explanatory notes to this Category)</p> <p>Fee: \$90.45 Benefit: 75% = \$67.85 85% = \$76.90</p>
12321	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the measurement of bone density 12 months following a significant change in therapy for:</p> <ul style="list-style-type: none"> . established low bone mineral density; or . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma. <p>Measurement of 2 or more sites - 1 service only in a period of 12 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12318 applies (Ministerial Determination). (See para D1.26 of explanatory notes to this Category)</p> <p>Fee: \$90.45 Benefit: 75% = \$67.85 85% = \$76.90</p>

NUCLEAR MEDICINE		NUCLEAR MEDICINE	
GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)			
12500	BLOOD VOLUME ESTIMATION Fee: \$191.45	Benefit: 75% = \$143.60	85% = \$162.75
12503	ERYTHROCYTE RADIOACTIVE UPTAKE SURVIVAL TIME TEST OR IRON KINETIC TEST Fee: \$375.35	Benefit: 75% = \$281.55	85% = \$319.05
12506	GASTROINTESTINAL BLOOD LOSS ESTIMATION involving examination of stool specimens Fee: \$268.00	Benefit: 75% = \$201.00	85% = \$227.80
12509	GASTROINTESTINAL PROTEIN LOSS Fee: \$191.45	Benefit: 75% = \$143.60	85% = \$162.75
12512	RADIOACTIVE B12 ABSORPTION TEST 1 isotope Fee: \$92.80	Benefit: 75% = \$69.60	85% = \$78.90
12515	RADIOACTIVE B12 ABSORPTION TEST 2 isotopes Fee: \$203.15	Benefit: 75% = \$152.40	85% = \$172.70
12518	THYROID UPTAKE (using probe) Fee: \$92.80	Benefit: 75% = \$69.60	85% = \$78.90
12521	PERCHLORATE DISCHARGE STUDY Fee: \$111.90	Benefit: 75% = \$83.95	85% = \$95.15
12524	RENAL FUNCTION TEST (without imaging procedure) Fee: \$139.90	Benefit: 75% = \$104.95	85% = \$118.95
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) Fee: \$75.05	Benefit: 75% = \$56.30	85% = \$63.80
12530	WHOLE BODY COUNT not being a service associated with a service to which another item applies Fee: \$111.90	Benefit: 75% = \$83.95	85% = \$95.15
‡ 12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled ¹³ CO ₂ or ¹⁴ CO ₂ , for either:- (a) the confirmation of <i>Helicobacter pylori</i> colonisation, OR (b) the monitoring of the success of eradication of <i>Helicobacter pylori</i> . Fee: \$74.75	Benefit: 75% = \$56.10	85% = \$63.55

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 speciality 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.

Items 13847 and 13848

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 38609 Management on each day subsequent to the first is covered under item 13848.

(a) "management" of counterpulsation of intraaortic balloon means full haemodynamic 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 Cytotoxic chemotherapy administration (Item 13915)

T1.10.1 Following a recommendation of a National Health and Medical Research Council review committee in 2005, Medicare benefits are no longer payable for professional services rendered for the purpose of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used in the therapy.

T1.11 Implanted Pump or Reservoir/Drug Delivery Device (Items 13939 and 13942)

T1.11.1 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.

T1.12 PUVA or UVB Therapy (Items 14050, 14053)

T1.12.1 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.

T1.13 Laser Photocoagulation (Items 14106 - 14124)

T1.13.1 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

T1.13.2 Item 14124 applies where additional treatments are indicated in a 12 month period and are only claimable for haemangiomas of infancy.

T1.14 Implantable Drug Delivery System for the treatment of severe chronic spasticity (Item 14227, 14230, 14233, 14236, 14239, 14242)

T1.14.1 Baclofen is provided under Section 100 of the Pharmaceutical Benefits Scheme for the following indications: Severe chronic spasticity, where oral agents have failed or have caused unacceptable side effects, in patients with chronic spasticity:

- (a) of cerebral origin; or
- (b) due to multiple sclerosis; or
- (c) due to spinal cord injury; or
- (d) due to spinal cord disease.

Items 14227 to 14242 should be used in accordance with these restrictions.

T1.15 Infliximab (Item 14245)

T1.15.1 Infliximab is provided under Section 100 of the Pharmaceutical Benefits Scheme for the following indications:

- Rheumatoid arthritis
- Ankylosing Spondylitis
- psoriatic arthritis

Item 14245 should be used in accordance with these restrictions.

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.

Explanatory Notes (addition of T2.2.3, T2.2.4, and T2.2.5)

T2.2 Planning Services (Items 15500 – 15562)

T2.2.1 A planning episode involves field setting and dosimetry. 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.

T2.2.3 Items 15500 to 15533 (inclusive) are for the purpose of a planning episode for two dimensional conformal radiotherapy. Items 15550 to 15562 (inclusive) are for the purpose of a planning episode for three dimensional conformal radiotherapy.

T2.2.4 It is expected that the 2D simulation items (15500, 15503, and 15506) would be used in association with the 2D planning items (15518, 15521, and 15524) in the course of a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in the course of a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in the course of a planning episode.

T2.2.5 The organs at risk must be clinically appropriate and clinical notes must contain information to support the use of a particular organ at risk.

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).

T4.1 Antenatal service provided by a nurse, midwife or a registered Aboriginal Health Worker (Item 16400)

T4.1.1 Item 16400 can only be claimed by a medical practitioner (including a vocationally registered or non-vocationally registered GP, a specialist or a consultant physician) where:

- an antenatal service is provided to a patient by a midwife, nurse or registered Aboriginal Health Worker on behalf of the medical practitioner at, or from an eligible practice location in a regional, rural or remote area.

T4.1.2 A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

T4.1.3 Evidence based national or regional guidelines should be used in the delivery of this antenatal service.

T4.1.4 An eligible practice location is the place associated with the medical practitioner's Medicare provider number from which the service has been provided. If you are unsure if the location is in an eligible area you can call Medicare Australia on 132 150.

T4.1.5 A midwife means a registered midwife who holds a current practising certificate as a midwife issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice.

T4.1.6 A nurse means a registered or enrolled nurse who holds a current practising certificate as a nurse issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice. The nurse must have appropriate training and skills to provide antenatal care.

T4.1.7 A registered Aboriginal Health Worker means an Aboriginal Health Worker who holds current registration issued by a State or Territory regulatory authority; and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice. This includes a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*. The Aboriginal Health Worker must have appropriate training and skills to provide antenatal care.

T4.1.8 The midwife, nurse or registered Aboriginal Health Worker must also comply with any relevant legislative or regulatory requirements regarding the provision of the antenatal service.

T4.1.9 The medical practitioner under whose supervision the antenatal service is provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the midwife, nurse or registered Aboriginal Health Worker is appropriately registered, qualified and trained, and covered by indemnity insurance to undertake antenatal services.

T4.1.10 Supervision at a distance is recognised as an acceptable form of supervision. This means that the medical practitioner does not have to be physically present at the time the service is provided. However, the medical practitioner should be able to be contacted if required.

T4.1.11 The medical practitioner is not required to see the patient or to be present while the antenatal service is being provided by the midwife, nurse or registered Aboriginal Health Worker. It is up to the medical practitioner to decide whether they need to see the patient. Where a consultation with the medical practitioner has taken place prior to or following the antenatal service, the medical practitioner is entitled to claim for their own professional service, but item 16400 cannot be claimed in these circumstances.

T4.1.12 Item 16400 cannot be claimed in conjunction with another antenatal attendance item for the same patient, on the same day by the same practitioner.

T4.1.13 A bulk billing incentive item (10990, 10991 or 10992) cannot be claimed in conjunction with item 16400. An incentive payment is incorporated into the schedule fee.

T4.1.14 Item 16400 can only be claimed 10 times per pregnancy.

T4.1.15 Item 16400 cannot be claimed for an admitted patient of a hospital or approved day facility.

OBSTETRICS (Group T4)

T4.2 Antenatal Care (Item 16500)

T4.2.1 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.

T4.2.2 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.

T4.2.3 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.

T4.3 External Cephalic Version for Breech Presentation (Item 16501)

T4.3.1 Contraindications for this item are as follows:

- antepartum haemorrhage (APH)
- multiple pregnancy,
- fetal anomaly,
- intrauterine growth retardation (IUGR),
- caesarean section scar,
- uterine anomalies,
- obvious cephalopelvic disproportion,
- isoimmunization,
- premature rupture of the membranes.

T4.4 Labour and Delivery (Items 16515, 16518, 16519, 16525)

T4.4.1 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.

T4.4.2 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.

T4.4.3 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.

T4.4.4 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.

T4.4.5 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.

T4.4.6 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.

T4.4.7 At a high risk delivery benefits will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the delivery) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk deliveries include cases of difficult vaginal delivery, Caesarean section or the delivery of babies with Rh problems and babies of toxæmic mothers.

T4.5 Caesarean Section (Item 16520)

T4.5.1 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.

T4.6 Complicated Confinement (Item 16522)

T4.6.1 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.

T4.7 Post-Partum Care (Items 16564-16573)

T4.7.1 The Schedule fees and benefits payable for Items 16519 and 16520 cover all postnatal attendances on the mother and the baby, except in the following circumstances:-

- (i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;
- (ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);
- (iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over while in labour from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the delivery;
- (iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;
- (v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

T4.7.2 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

T4.7.3 Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract benefits

T4.7.4 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.

T4.8 Interventional Techniques (16600-16636)

T4.8.1 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 II 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.

T4.8.2 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-anaesthesia Consultations

T6.1.1 From 1 November 2006, pre-anaesthesia consultations are covered by new items in the range 17610 - 17625. These new items replace item 17603, which has been deleted from the Medicare Benefits Schedule.

T6.1.2 Pre-anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. A pre-anaesthesia consultation will attract benefits under the appropriate items based on BOTH the duration of the consultation AND the complexity of the consultation in accordance with the requirements outlined in the content-based item descriptions.

T6.1.3 Whether or not the proposed procedure proceeds, the pre-anaesthetic attendance will attract benefits under the appropriate consultation item in the range 17610 – 17625, as determined by the duration and content of the consultation.

T6.1.4 The following provides further guidance on utilisation of the appropriate items in common clinical situations:

(i) Item 17610 (15 mins or less) – a pre-anaesthesia consultation of a straightforward nature occurring prior to investigative procedures and other routine surgery. This item covers routine pre-anaesthesia consultation services including the taking of a brief history, a limited examination of the patient including the cardio-respiratory system and brief discussion of an anaesthesia plan with the patient.

(ii) Item 17615 (16-30 mins) - a pre-anaesthesia consultation of between 16 to 30 minutes duration AND of significantly greater complexity than that required under item 17610. To qualify for benefits patients will be undergoing advanced surgery or will have complex medical problems. The consultation will involve a more extensive examination of the patient, for example: the cardio-respiratory system, the upper airway, anatomy relevant to regional anaesthesia and invasive monitoring. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

(iii) Item 17620 (31-45 mins) – a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and of between 31 to 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations and the formulation of an anaesthesia plan of management of which there should be a written record in the patient notes.

(iv) Item 17625 (more than 45 mins) - a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and item 17620 and of more than 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations as well as discussion of the patient's medical condition and/or anaesthesia plan of management with other relevant healthcare professionals. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

Some examples of advanced surgery that may require a longer consultation under items 17615-17625 would include:

- Bowel resection
- Caesarean section
- Neonatal surgery
- Major laparotomies
- Radical cancer resection
- Major reconstructive surgery eg free flap transfers, breast reconstruction
- major joint arthroplasty
- joint reconstruction
- Thoracotomy
- Craniotomy
- Spinal surgery eg spinal fusion, discectomy
- Major vascular surgery eg aortic aneurysm repair, arterial bypass surgery, carotid artery endarterectomy

Some examples of complex medical problems in relation to items 17615-17625 would include:

- Major cardiac problems – e.g cardiomyopathy, unstable ischaemic heart disease, heart failure
- Major respiratory disease – e.g COPD, respiratory failure, acute lung conditions eg. infection and asthma,
- Major neurological conditions – CVA, intra/extra cerebral haemorrhage, cerebral palsy and/or major intellectual disability, degenerative conditions of the CNS
- Major metabolic conditions – e.g unstable diabetes, uncontrolled hyperthyroidism, renal failure, liver failure, immune deficiency

- Anaesthetic problems – eg past history of awareness, known or anticipated difficulty with securing the airway, malignant hyperpyrexia, drug allergy,
- Other conditions –
 - patients with history of stroke/TIA's presenting for vascular surgery
 - patients on anti-platelet agents presenting for major surgery requiring management of anticoagulant status
 - patients with poor respiratory/cardiac function presenting for major surgery requiring management of perioperative medications, analgesia and monitoring

NOTE I:

It is important to note that:

- patients undergoing the types of advanced surgery listed above but who are otherwise of reasonable health and who, therefore, do not require a longer pre-anaesthesia consultation as provided for under items 17615-17625, would qualify for benefits under item 17610; and
- not all patients with complex medical problems will qualify for a longer consultation under items 17615-17625. For example, patients who have reasonably stable diabetes may only require a short consultation, covered under item 17610. Similarly, patients with reasonably well controlled emphysema (COPD) undergoing minor surgery may only require a short pre-anaesthesia consultation (item 17610), whereas the same patient scheduled for an upper abdominal laparotomy and with recent onset angina with the possible need for ICU postoperatively may require a longer consultation.

NOTE II

- Consultation services covered by pain specialists items in the range 2801-3000 cannot be claimed in conjunction with items 17610-17625
- The consultation time under items 17610 – 17625 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.
- The requirement of a written patient management plan in items 17615-17625 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

T6.2 Referred Anaesthesia Consultations (Items 17640 to 17655)

T6.2.1 From 1 November 2006, anaesthesia referred consultations (other than pre-anaesthesia attendances) where the patient is referred will be covered by new items in the range 17640 - 17655. These new items replace the use of specialist referred items 104 and 105. Items 104 and 105 will no longer apply to referred anaesthesia consultations provided by specialist anaesthetists.

T6.2.2 Referred anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. Services covered by these specialist referred items include consultations in association with the following:

- (i) Acute pain management
 - Postoperative, utilising specialised techniques eg Patient Controlled Analgesia System (PCAS)
 - as an independent service eg pain control following fractured ribs requiring nerve blocks
 - obstetric pain management
- (ii) Perioperative management of patients
 - postoperative management of cardiac, respiratory and fluid balance problems following major surgery
 - vascular access procedures (other than intra-operative peripheral vascular access procedures)

T6.2.3 Items 17645 – 17655 will involve the examination of multiple systems and the formulation of a written management plan. Items 17650 and 17655 would also entail the ordering and/or evaluation of relevant patient investigations.

NOTE :

- It should be noted that the consultation time under items 17640 – 17655 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.
- Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with items 17640 – 17655.
- The requirement of a written patient management plan in items 17645-17655 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

T6.2.3 It would be expected that in the vast majority of cases, the insertion of a peripheral venous cannula (other than in association with anaesthesia) where the patient is referred, would attract benefit under item 17640. However, in exceptional clinical circumstances, where the procedure is considerably more difficult and exceeds 15 minutes, such as for patients with chronic disease undergoing long term intravenous therapy, paediatric patients or patients having chemotherapy, item 17645 would apply.

T6.3 ANAESTHETIST CONSULTATIONS - OTHER (Items 17680, 17690)

T6.3.1 A consultation occurring immediately before the institution of major regional blockade for a patient in labour is covered by item 17680.

T6.3.2 Item 17690 can only be claimed where all of the conditions set out in (a) to (d) of item 17690 have been met.

T6.3.3 Item 17690 can only be claimed in conjunction with a service covered by items 17615, 17620, or 17625.

T6.3.4 Item 17690 cannot be claimed where the pre-anaesthesia consultation covered by items 17615, 17620 or 17625 is provided on the same day as admission to hospital for the subsequent episode of care involving anaesthesia services.

NOTE: Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with anaesthesia consultation items 17610 - 17690.

REGIONAL OR FIELD NERVE BLOCKS (Group T7)

T7.1 General

T7.1.1 A nerve block is interpreted as the anaesthetising of a substantial segment of the body innervated by a large nerve or an area supplied by a smaller nerve where the technique demands expert anatomical knowledge and a high degree of precision.

T7.1.2 Where anaesthesia combines a regional nerve block with general anaesthesia for an operative procedure, benefit will be paid only under the relevant anaesthesia item as set out in Group T10.

T7.1.3 Where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block attracts benefits under the Group T10 anaesthesia item and not the block item in Group T7.

T7.1.4 Where a regional or field nerve block which is covered by an item in Group T7 is administered by a medical practitioner in the course of a surgical procedure undertaken by that practitioner, then such a block will attract benefit under the appropriate Group T7 item.

T7.1.5 When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

T7.1.6 Digital ring analgesia, local infiltration into tissue surrounding a lesion or paracervical (uterine) analgesia are not eligible for the payment of Medicare benefits under items within Group T7. Where procedures are carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure.

T7.2 Maintenance of Regional or Field Nerve Block (Items 18222, 18225)

T7.2.1 Medicare benefit is attracted under these items only when the service is performed other than by the operating surgeon. This does not preclude benefits for an obstetrician performing an epidural block during labour.

T7.2.2 When the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare. In these circumstances a Medicare benefit is not attracted.

T7.3 Intrathecal or Epidural Injection (Item 18232)

T7.3.1 This item covers caudal infusion/injection.

T7.4 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 carpal 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 larynx or trachea;
- (iii) the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item 30067/30068) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

T8.3 Not Being a Service Associated with a Service to which another Item in this Group Applies

T8.3.1 "Not being a service associated with a service to which another item in this Group applies" means that benefit is not payable for any other item in that Group when it is performed on the same occasion as this item. eg item 30106.

T8.3.2 "Not being a service associated with a service to which Item applies" means that when this item is performed on the same occasion as the reference item no benefit is payable. eg item 39330.

T8.4 Not Being a Service to which another Item in this Group Applies

T8.4.1 "Not being a service to which another item in this Group applies" means that this item may be itemised if there is no specific item relating to the service performed, e.g. Item 30387 (Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies). Benefits may be attracted for an item with this qualification as well as benefits for another service during the course of the same operation.

T8.5 Multiple Operation Formula

T8.5.1 The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion (except as provided in paragraph T8.5.3) are calculated by the following rule:-

- 100% for the item with the greatest Schedule fee
- plus 50% for the item with the next greatest Schedule fee
- plus 25% for each other item.

Note:

- (a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.
- (b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
- (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 All care directly related to a public in-patient's care should be provided free of charge. Where a patient has received in-patient treatment in a hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act), routine and non-routine aftercare directly related to that episode of admitted care would usually be provided free of charge as part of the public hospital service, on behalf of the state or territory as required by the Australian Health Care Agreement. In this case no Medicare benefit is payable.

However, aftercare provided to a public patient by a private medical practitioner may attract Medicare benefits on an attendance basis in certain circumstances. The circumstances in which a benefit may be payable are:

- (1) where the state or territory was not providing such services free of charge in the locality as at 1 July 1998; or
- (2) when a patient independently chooses to consult a medical practitioner other than the one nominated by the hospital.

If a practitioner is not already being paid by the hospital to provide aftercare services and thinks that the circumstance outlined in (1) above may apply, it would be advisable to seek written information from the hospital or the state/territory health authority on the 1 July 1998 availability of such service, and ensure that the written advice is retained in connection with each such invoice, receipt or assignment form.

T8.7.7 When a surgeon delegates after-care to a local doctor, Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the after-care. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.

T8.7.8 In respect of fractures, where the after-care is delegated to a doctor at a place other than the place where the initial reduction is carried out, benefit may be apportioned on a 50:50 basis rather than on the 75:25 basis suggested for surgical operations.

T8.7.9 Where the reduction of a fracture is carried out by hospital staff in the out-patient or casualty department of a recognised hospital and the patient is then referred to a private practitioner for supervision of the after-care, Medicare benefits are payable for the after-care treatment on an attendance basis.

T8.7.10 The following table shows the period which has been adopted as reasonable for the after-care of fractures:-

(Note: This list is a guide only and each case should be judged on individual merits. See paragraphs T8.7.2 to T8.7.4 above.)

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
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 These items cannot be claimed for selective internal radiation therapy (SIRT). See items 35404, 35406 and 35408 for SIRT using SIR_Spheres (yttrium-90 microspheres).

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.

T8.11.3 Items 30071-30096 require that the specimen be sent for pathological examination.

T8.11.4 The aftercare period for item 30071 is 2 days rather than the standard aftercare period for skin excision of 10 days.

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 45569 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 the Commission, 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 Uterine Artery Embolisation (Item 35410)

T8.36.1 This item was introduced on an interim basis in November 2006 following a recommendation of the Medical Services Advisory Committee (MSAC). Medicare coverage is available for five years until November 2011, before which time MSAC will review the results of trials conducted in the intervening period. The requirement for specialist referral by a gynaecologist for uterine artery embolisation was a MSAC recommendation. Providers should retain the instrument of specialist referral for each patient for 18 months from the date of the procedure, as this may be subject to audit by Medicare Australia.

T8.37 Endovascular Coiling of Intracranial Aneurysms (Item 35412)

This service includes balloon angioplasty and insertion of stents (assisted coiling) associated with intracranial aneurysm coiling. The use of liquid embolics alone is not covered by this item. Digital Subtraction Angiography (DSA) done to diagnose the aneurysm (items 60009 and either 60072, 60075 or 60078) is claimable, however this must be clearly noted on the claim and in the clinical notes as separate from the intra-operative DSA done with the coiling procedure.

T8.38 Arterial and Venous Patches (Items 33545-33551, 34815)

T8.38.1 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.

T8.38.2 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.

T8.38.3 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.

T8.39 Embolectomy or Thrombectomy (Item 33806)

T8.39.1 Benefit is payable once only per extremity, regardless of the number of incisions required to access the artery or bypass graft.

T8.40 Carotid percutaneous transluminal angioplasty with stenting (Item 35307)

T8.40.1 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.

T8.40.2 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.

T8.41 Peripheral Arterial or Venous Catheterisation (Item 35317)

T8.41.1 Item 35317 is restricted to the use of those chemotherapeutic agents other than antibiotic or antiviral agents.

T8.42 Peripheral Arterial or Venous Embolisation (Item 35321)

T8.42.1 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).

T8.43 Vertebroplasty (Items 35400, 35402)

T8.43.1 Items 35400 and 35402 have been introduced on an interim basis following a recommendation of the Medical Services Advisory Committee (MSAC). The MSAC assessment of vertebroplasty showed that finding either bone oedema or gas cleft on a magnetic resonance image was the most effective way of confirming that vertebroplasty would be effective in relieving pain due to osteoporotic vertebral compression fractures; the absence of either of these findings on a magnetic resonance image is considered a contra-indication to vertebroplasty.

T8.43.2 The items do not cover the cost of the cement injected during the procedure. Where a charge is made for the cement, it must be separately listed on the account and not billed to Medicare.

T8.44 Selective Internal Radiation Therapy (SIRT) using SIR-Spheres (Items 35404, 35406, 35408)

T8.44.1 These items were introduced into the Schedule on an interim basis in May 2006 following a recommendation of the Medical Services Advisory Committee (MSAC). Medicare funding for these items is available for four years until May 2010, before which time MSAC will review the results of trials conducted in the intervening period. SIRT should not be performed in an outpatient or day patient setting to ensure patient and radiation safety requirements are met.

T8.45 Intravascular Brachytherapy for Coronary Artery Restenoses (Items 38321 - 38330)

T8.45.1 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).

T8.46 Percutaneous Transluminal Rotational Atherectomy (Items 38309, 38312, 38315, 38318)

T8.46.1 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.

T8.46.2 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.

T8.47 Colposcopic Examination (Item 35614)

T8.47.1 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.

T8.48 Hysteroscopy (Item 35626)

T8.48.1 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.

T8.49 Curettage of Uterus under GA or Major Nerve Block (Items 35639, 35640)

T8.49.1 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.

T8.50 Neoplastic Changes of the Cervix (Items 35644-35648)

T8.50.1 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.

T8.51 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. 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*.

T8.52 Debulking of Uterus (Item 35658)

T8.52.1 Benefits are payable under Item 35658, using the multiple operation rule, in addition to vaginal hysterectomy.

T8.53 Reversal of Sterilisation (Items 35700, 37616 and 37619)

T8.53.1 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.

T8.53.2 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.

T8.53.3 Claims for Medicare benefits in respect of items 35700, 37616 and 37619 should be accompanied by detailed clinical reasons for the reversal.

T8.53.4 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.

T8.54 Nephrectomy (Items 36526 and 36527)

T8.54.1 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.

T8.55 Selective Coronary Angiography (items 38215-38246)

T8.55.1 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.

T8.55.2 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.

T8.55.3 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.

T8.55.4 Items in the range 38215 - 38246 cannot be claimed for any intravascular ultrasound (IVUS) procedure therefore Medicare Benefits are not payable for IVUS.

T8.56 Transurethral Needle Ablation (TUNA) of the Prostate

T8.56.1 Moderate to severe lower urinary tract symptoms are defined using the American Urological Association (AUA) Symptom Score or the International Prostate Symptom Score (IPSS).

T8.56.2 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.

T8.56.3 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).

T8.57 Ureteroscopy (Item 36803)

T8.57.1 Item 36803 refers to ureteroscopy of one ureter when performed for the purpose of inspection alone. It may not be used when one of the other ureteroscopy numbers (Items 36806 or 36809) or pyeloscopy numbers (Items 36652, 36654 or 36656) is used for a ureteroscopic procedure performed in the same ureter or collecting system. It may be used when inspection alone is carried out in one ureter independently from a ureteroscopic or pyeloscopy procedure in another ureter or collecting system. If Item number 36803 is used with one of the other above 5 numbers, it must be specified that item number 36803 refers to ureteroscopy performed in another ureter eg 36654 (Right side) and 36803 (Left side). 36803 may

also be used in this way if there is a partial or complete duplex collecting system eg 36809 (Lower pole moiety ureter, Left side) and 36803 (Upper pole moiety ureter, Left side).

T8.57.2 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).

T8.58 Brachytherapy of the Prostate (Item 37220)

T8.58.1 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.

T8.58.2 An approved site is one that has been licensed by the relevant Radiation Advisory Body.

T8.59 High Dose Rate Brachytherapy (Item 37227)

T8.59.1 Item 37227 covers the services undertaken by a urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

T8.60 Radical or Debulking Operation for Ovarian Tumour including Omentectomy (Item 35720)

T8.60.1 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.

T8.61 Cardiac Pacemaker Insertion (Items 38209, 38212, 38353, 38356)

T8.61.1 The fees for the insertion of a pacemaker (Items 38353 and 38356) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function. Accordingly, additional benefits are not payable for such routine testing under Item 38209 or 38212 (Cardiac electrophysiological studies).

T8.62 Implantable ECG Loop Recorder (Item 38285)

T8.62.1 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.

T8.62.2 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).

T8.63 Transluminal Insertion of Stent or Stents (Item 38306)

T8.63.1 Item 38306 should only be billed once per occlusional site. It is not appropriate to bill item 38306 multiple times for the insertion of more than one stent at the same occlusional site in the same artery. However, it would be appropriate to claim this item multiple times for insertion of stents into the same artery at different occlusional sites or into another artery or occlusional site. It is expected that the practitioner will note the details of the artery or site into which the stents were placed, in order for Medicare Australia to process the claims.

T8.64 Permanent cardiac synchronisation device (Items 38365, 38368, 38654)

T8.64.1 Items 38365, 38368 and 38654 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had a CRT device and transvenous left ventricular electrode inserted and who prior to its insertion met the criteria and now need the device replaced.

T8.65 Intravascular extraction of permanent pacing leads (Item 38358)

T8.65.1 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 Medicare Australia notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

T8.66 Cardiac Resynchronisation Therapy (Item 38371)

T8.66.1 Item 38371 applies only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an CRT device capable of defibrillation inserted and who prior to its insertion met the criteria and now need the device replaced.

T8.67 Implantable Cardioverter Defibrillator (Items 38384, 38387)

T8.67.1 Items 38384 and 38387 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an ICD device inserted and who prior to its insertion met the criteria and now need the device replaced.

T8.68 Cardiac and Thoracic Surgical Items (38470 to 38766)

T8.68.1 Items 38470 to 38766 are only to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor and the Regulations.

T8.69 Coronary Artery Bypass (Items 38497 - 38504)

T8.69.1 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.

T8.69.2 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.

T8.69.3 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.

T8.70 Re-operation via Median Sternotomy (Item 38640)

T8.70.1 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.

T8.71 Skull Base Surgery (Items 39640 - 39662)

T8.71.1 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.

T8.71.2 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.

T8.72 Intradiscal Injection of Chymopapain (Item 40336)

T8.72.1 The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

T8.73 Removal of Ventilating Tube from Ear (Item 41500)

T8.73.1 Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

T8.74 Meatoplasty (Item 41515)

T8.74.1 When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

T8.75 Reconstruction of Auditory Canal (Item 41524)

T8.75.1 When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

T8.76 Removal of Nasal Polyp or Polypi (Items 41662, 41665, 41668)

T8.76.1 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.

T8.77 Larynx, Direct Examination (Item 41846)

T8.77.1 Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

T8.78 Microlaryngoscopy (Item 41858)

T8.78.1 This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

T8.79 Imbedded Foreign Body (Item 42644)

T8.79.1 For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and would require the use of magnification and surgical removal.

T8.80 Corneal Incisions (Item 42672)

T8.80.1 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.

T8.81 Capsulectomy or Lensectomy (Item 42731)

T8.81.1 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		

T8.81.2 This list of exclusions was developed following consultation with the Royal Australian and New Zealand College of Ophthalmologists.

T8.82 Cyclodestructive Procedures (Items 42770 and 42771)

T8.82.1 Item 42770 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period item 42771 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in-Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.83 Laser Trabeculoplasty (Items 42782, 42783)

T8.83.1 Item 42782 is restricted to a maximum of 4 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42783 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.84 Laser Iridotomy (Items 42785, 42786)

T8.84.1 Item 42785 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42786 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.85 Laser Capsulotomy (Items 42788, 42789)

T8.85.1 Item 42788 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42789 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.86 Laser Vitreolysis or Corticolysis of lens material or Fibrinolysis (Items 42791, 42792)

T8.86.1 Item 42791 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42792 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.87 Division of Suture by Laser (Item 42794)

T8.87.1 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.

T8.88 Laser Coagulation of Corneal or Scleral Blood Vessels (Item 42797)

T8.88.1 Benefits under this item are restricted to 4 treatments in a 2 year period. There is no provision for additional treatments in that period.

T8.88.2 Benefits are not payable under Item 42797 for procedures undertaken for cosmetic purposes (see paragraph 13.1.2 of the General Explanatory Notes).

T8.89 Ophthalmic Sutures (Item 42845)

T8.89.1 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, or adjustment performed prior to the patient leaving the operating theatre.

T8.90 Full Face Chemical Peel (Items 45019, 45020)

T8.90.1 These items relate to full face chemical peel in the circumstances outlined in the item descriptors. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to confirm that the conditions for payment of benefits have been met. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.91 Abrasive Therapy/Resurfacing (Items 45021 - 45026)

T8.91.1 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.

T8.91.2 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.

T8.92 Foreign Implant (Item 45051)

T8.92.1 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.

T8.93 Escharotomy (Item 45054)

T8.93.1 Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

T8.94 Local Skin Flap – Definition

T8.94.1 Medicare benefits for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks, maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures

T8.94.2 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.

T8.94.3 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.

T8.94.4 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.

T8.94.5 Items where benefit for local skin flap repair (if indicated as above) is payable, include:

30023, 30180, 30186, 30269, 31205-31340, 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.

T8.94.6 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, 31200, 45520, 45522, 45524, 45563, 45587, 45632-45644, 45659, 45662, 45677-45713.

T8.95 Free grafting to burns (Items 45406 - 45418)

T8.95.1 Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

T8.96 Revision of scar (Items 45506 to 45518)

T8.96.1 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 of facial aperture.

T8.96.2 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.

T8.96.3 Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

T8.96.4 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.

T8.97 Reduction Mammoplasty (Item 45522)

T8.97.1 Medicare benefits are not payable under item 45522 for gynaecomastia. The treatment of gynaecomastia is provided for under either item 31527 or 45585.

T8.98 Augmentation Mammoplasty (Items 45524, 45527, 45528)

T8.98.1 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 mammoplasty 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 mammoplasty services performed using fat transfer to the breast.

T8.98.2 Item 45528 applies where bilateral mammoplasty is indicated because of malformation of breast tissue, disease or trauma of the breast, (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked 'Medical-in-Confidence'. (See note 8.6 of the General Explanatory Notes).

T8.99 Breast Reconstruction, Myocutaneous Flap (Item 45530)

T8.99.1 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.

T8.99.2 When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

T8.99.3 Items 30165, 30168, 30171, 30174 or 30177 (lipectomy items) should not be claimed in association with item 45530 as stated in the *Health Insurance (General Medical Services Table) Regulations*.

T8.100 Breast prosthesis, removal and replacement of (items 45552 – 45555)

T8.100.1 Medicare benefits are only payable for services under items 45552 – 45555 where the replacement prosthesis is the same size as the prosthesis that is removed.

T8.101 Breast Ptosis (Items 45556, to 45559)

T8.101.1 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 mammoplasty is performed simultaneously on the same side.

T8.101.2 Items 45557 and 45558 apply where correction of breast ptosis is indicated because the nipple is inferior to the infra-mammary groove.

T8.101.3 Claims for benefits for items 45557, 45558 and 45559 should be accompanied by full clinical details including colour photographs including an anterolateral view. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in-Confidence'. (See note 8.6 of the General Explanatory Notes.) These items are payable only once per patient.

T8.102 Nipple and/or Areola Reconstruction (Item 45545, 45546)

T8.102.1 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.

T8.102.2 Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

T8.103 Liposuction (Items 45584, 45585 and 45586)

T8.103.1 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.

T8.103.2 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, lymphoedema or macrodystrophia lipomatosa item 45585 applies. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative photographs of the whole body including laterals including the abdomen and breasts. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.103.3 Photos for pre-approval of liposuction of the gynaecomastia under item 45585 should be sent to the Medicare Claims Review Panel post subcutaneous mastectomy and prior to having liposuction.

T8.103.4 Claims for benefits under item 45586 should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.104 Meloplasty for Correction of Facial Asymmetry (Items 45587, 45588)

T8.104.1 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.

T8.104.2 Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooping from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.104.3 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.

T8.105 Reduction of Eyelids (Items 45617, 45620)

T8.105.1 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.

T8.106 Rhinoplasty (45638, 45639)

T8.106.1 Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

T8.106.2 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.

T8.106.3 Item 45639 applies where surgery is indicated for the correction of significant developmental deformity. Developmental deformity includes cleft nose, bifid tip and twisted nose. Claims for benefits under this item should be accompanied by full clinical details and pre-operative photographs, including front, base (ie inferior view) and two laterals of the nose. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.107 Contour Restoration (Item 45647)

T8.107.1 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.

T8.108 Vermilionectomy (Item 45669)

T8.108.1 Item 45669 covers treatment of the entire lip.

T8.109 Osteotomy of Jaw (Items 45720 - 45752)

T8.109.1 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.

T8.109.2 For the purposes of these items, a reference to maxilla includes the zygoma.

T8.110 Genioplasty (Items 45761)

T8.110.1 Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

T8.111 Tumour, cyst, ulcer or scar (Items 45801 - 45813)

T8.111.1 It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

T8.112 Reduction of Dislocation or Fracture

T8.112.1 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.

T8.112.2 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.

T8.112.3 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.

T8.112.4 The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

T8.113 Lumbar Discectomy (Item 48636)

T8.113.1 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.

T8.114 Discectomy in relation to anterior interbody spinal fusion (Items 48660-48675)

T8.114.1 Benefits are not payable for discectomy items claimed in association with anterior interbody fusion items unless discectomy is required to remove expelled fragments of disc or is undertaken at a level different from where the fusion is performed.

T8.115 Internal Fixation (Items 48678-48690)

T8.115.1 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.

T8.116 Lumbar Artificial Intervertebral Total Disc Replacement (Items 48691-48693)

T8.116.1 These items were introduced on an interim basis in November 2006 following a recommendation of the Medical Services Advisory Committee (MSAC). Medicare coverage is available for three years until November 2009 before which time MSAC will review the results of trials conducted in the intervening period.

T8.117 Wrist Surgery (Items 49200-49227)

T8.117.1 For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

T8.118 Joint or other Synovial Cavity, Aspiration of, or Injection into (Items 50124, 50125)

T8.118.1 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.)

T8.119 Paediatric patients (Items 50450 – 50658)

T8.119.1 For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state "with open growth plates").

T8.120 Treatment of fractures in paediatric patients (Items 50500 – 50588)

T8.120.1 Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

T8.120.2 Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

T8.120.3 Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

T8.121 Non-resectable Hepatocellular Carcinoma Destruction of by Open or Laparoscopic Radiofrequency Ablation (50952)

T8.121.1 A multi-disciplinary team for the purposes of item 50952 would include a hepatobiliary 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

Item A - \$300@100%
Item B - \$250@50%
Item C - \$200@25%
Item D - \$150@25%

Multiple Operation Rule - Assistant

Item A (Assist.) - \$300@100%
Item B (No Assist.)
Item C (Assist.) - \$200@50%
Item D (Assist.) - \$150@25%

T9.5.2 The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

T9.6 Surgeons Operating Independently

T9.6.1 Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

T9.7 Assistance at Cataract and Intraocular Lens Surgery

T9.7.1 The reference to “previous significant surgical complication” covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

RELATIVE VALUE GUIDE FOR ANAESTHESIA (Group T10)

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_guidelines/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 biopsy (4 basic units) Fee: \$70.00 Benefit: 75% \$55.00 85% \$59.50
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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: \$52.50 Benefit: 75%= \$39.40 85% = \$ 44.65
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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: \$17.50 Benefit: 75% \$13.15 85% \$14.90
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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 \$87.50 (5 basic units) plus an item in the range 23010-24136) plus, where applicable, an item/s in the range 25000 – 25020
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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: \$350.00 Benefit: 75% = \$262.50 85% = \$297.50
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(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: \$52.50 Benefit: 75%= \$39.40 85% = \$ 44.65
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plus, where appropriate

(c) **modifying** units recognising certain added complexities in perfusion (an item/s in the range 25000 – 25020) for example

‡ 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: \$17.50 Benefit: 75% \$13.15 85% \$14.90
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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: \$17.50 Benefit: 75%= \$13.15 Benefit: 85% = \$14.90
23021	- 16 MINUTES TO 20 MINUTES (2 units) Fee: \$35.00 Benefit: 75%= \$26.25 Benefit: 85% = \$29.75
23022	- 21MINUTES to 25 MINUTES (2 units) Fee: \$35.00 Benefit: 75%= \$26.25 Benefit: 85% = \$29.75
23023	- 26 MINUTES to 30 MINUTES (2 units) Fee: \$35.00 Benefit: 75%= \$26.25 Benefit: 85% = \$29.75
23031	- 31 MINUTES to 35 MINUTES (3 units) Fee: \$52.50 Benefit: 75%= \$39.40 Benefit: 85% = \$44.65
23032	- 36 MINUTES to 40 MINUTES (3 units) Fee: \$52.50 Benefit: 75%= \$39.40 Benefit: 85% = \$44.65
23033	- 41 MINUTES to 45 MINUTES (3 units) Fee: \$52.50 Benefit: 75%= \$39.40 Benefit: 85% = \$44.65

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
RVG	Anaesthesia Service	Units	SCHEDULE FEE (Units x \$ 17.50)
20840	Anaesthesia for resection of perforated bowel	6	\$105.00
23190	Time – 4 hours 40 minutes	24	\$420.00
25000	Modifier - Physical status	1	\$17.50
22012	Central Venous Pressure Monitoring	3	\$52.50

T10.4.2 After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x \$17.50)
20840	Anaesthesia for resection of perforated bowel	6	\$ 105.00
23190	Time – 4 hours 40 minutes	24	\$420.00
25000	Modifier - Physical status	1	\$ 17.50
22012	Central Venous Pressure Monitoring	3	\$52.50
	TOTAL UNITS	34	Schedule fee = \$595.00
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee \$ 595.00 x 50% = 297.50

T10.4.3 Definition of Radical Surgery

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems.

T10.4.4 Multiple Anaesthesia Services

T10.4.4.1 Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE
20790	Anaesthesia for Cholecystectomy	8	\$ 140.00
20752	Incisional Hernia	6	\$ 105.00
23111	Time – 2hrs 30mins	11	\$192.50
25015	Physical Status – Over 70	1	\$ 17.50

T10.4.5 Prolonged Anaesthesia

T10.4.5.1 Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

T10.5 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
- (v) 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 the Commission, in a sealed envelope marked ‘Medical-in Confidence’. (See note 8.6 of the General Explanatory Notes.)

T10.12 Discontinued Procedure (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, including details of the surgery/procedure which had been proposed and the reason for it 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 the Commission, 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 Maxillofacial 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)

T10.18.1 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.

T11.1 Botulinum Toxin (Items 18350 - 18373)

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 Medicare Australia 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.

MISCELLANEOUS		HYPERBARIC OXYGEN THERAPY	
GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES			
SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY			
13020	<p>HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance (See para T1.1 of explanatory notes to this Category)</p>	Fee: \$228.65	Benefit: 75% = \$171.50 85% = \$194.40
13025	<p>HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour) (See para T1.1 of explanatory notes to this Category)</p>	Fee: \$102.25	Benefit: 75% = \$76.70 85% = \$86.95
13030	<p>HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour) (See para T1.1 of explanatory notes to this Category)</p>	Fee: \$144.40	Benefit: 75% = \$108.30 85% = \$122.75
SUBGROUP 2 - DIALYSIS			
13100	<p>SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day (See para T1.2 of explanatory notes to this Category)</p>	Fee: \$120.75	Benefit: 75% = \$90.60 85% = \$102.65
13103	<p>SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day (See para T1.2 of explanatory notes to this Category)</p>	Fee: \$62.90	Benefit: 75% = \$47.20 85% = \$53.50
13104	<p>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)</p>	Fee: \$130.75	Benefit: 85% = \$111.15
13106	<p>DECLOTTING OF AN ARTERIOVENOUS SHUNT</p>	Fee: \$107.25	Benefit: 75% = \$80.45 85% = \$91.20
13109	<p>INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)</p>	Fee: \$201.20	Benefit: 75% = \$150.90 85% = \$171.05
13110	<p>TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes.)</p>	Fee: \$201.90	Benefit: 75% = \$151.45 85% = \$171.65
13112	<p>PERITONEAL DIALYSIS, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.)</p>	Fee: \$120.75	Benefit: 75% = \$90.60 85% = \$102.65
SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES			
13200	<p>ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures) involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13203, 13206 or 13218 applies - being services rendered during 1 treatment cycle, if the duration of the treatment cycle is at least 9 days (See para T1.4 of explanatory notes to this Category)</p>	Fee: \$1,766.65	Benefit: 75% = \$1,325.00 85% = \$1,702.75

MISCELLANEOUS	PAEDIATRIC & NEONATAL
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 <i>(See para T1.4 of explanatory notes to this Category)</i> Fee: \$441.70 Benefit: 75% = \$331.30 85% = \$377.80
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 <i>(See para T1.4 of explanatory notes to this Category)</i> Fee: \$757.05 Benefit: 75% = \$567.80 85% = \$693.15
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 <i>(See para T1.4 of explanatory notes to this Category)</i> Fee: \$75.60 Benefit: 75% = \$56.70 85% = \$64.30
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.) <i>(See para T1.4 of explanatory notes to this Category)</i> Fee: \$321.80 Benefit: 75% = \$241.35 85% = \$273.55
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.) <i>(See para T1.4 of explanatory notes to this Category)</i> Fee: \$101.00 Benefit: 75% = \$75.75 85% = \$85.85
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.) <i>(See para T1.4 of explanatory notes to this Category)</i> Fee: \$757.05 Benefit: 75% = \$567.80 85% = \$693.15
13221	PREPARATION OF SEMEN for the purposes of assisted reproductive technologies or for artificial insemination <i>(See para T1.4 of explanatory notes to this Category)</i> Fee: \$46.10 Benefit: 75% = \$34.60 85% = \$39.20
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: \$180.50 Benefit: 75% = \$135.40 85% = \$153.45
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: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00
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: \$50.35 Benefit: 75% = \$37.80 85% = \$42.80
13303	UMBILICAL ARTERY CATHETERISATION with or without infusion Fee: \$74.60 Benefit: 75% = \$55.95 85% = \$63.45
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor Fee: \$295.15 Benefit: 75% = \$221.40 85% = \$250.90
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected Fee: \$251.70 Benefit: 75% = \$188.80 85% = \$213.95

MISCELLANEOUS	CARDIOVASCULAR
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS Fee: \$25.10 Benefit: 75% = \$18.85 85% = \$21.35
13318	CENTRAL VEIN CATHETERISATION (via jugular or subclavian vein) - by open exposure in a person under 12 years of age (Anaes.) Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.) Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
SUBGROUP 5 - CARDIOVASCULAR	
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.) Fee: \$85.55 Benefit: 75% = \$64.20 85% = \$72.75
SUBGROUP 6 - GASTROENTEROLOGY	
13500	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant IN THE ABSENCE OF GASTROINTESTINAL HAEMORRHAGE Fee: \$159.35 Benefit: 75% = \$119.55 85% = \$135.45
13503	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant FOR UPPER GASTROINTESTINAL HAEMORRHAGE Fee: \$318.70 Benefit: 75% = \$239.05 85% = \$270.90
13506	GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices Fee: \$163.00 Benefit: 75% = \$122.25 85% = \$138.55
SUBGROUP 8 - HAEMATOLOGY	
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) Fee: \$294.50 Benefit: 75% = \$220.90 85% = \$250.35
13703	ADMINISTRATION OF BLOOD, including collection from donor Fee: \$105.55 Benefit: 75% = \$79.20 85% = \$89.75
13706	ADMINISTRATION OF BLOOD or bone marrow already collected <i>(See para T1.5 of explanatory notes to this Category)</i> Fee: \$73.70 Benefit: 75% = \$55.30 85% = \$62.65
13709	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation <i>(See para T1.6 of explanatory notes to this Category)</i> Fee: \$42.80 Benefit: 75% = \$32.10 85% = \$36.40
13750	THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies -payable once per day Fee: \$120.75 Benefit: 75% = \$90.60 85% = \$102.65
13755	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day Fee: \$120.75 Benefit: 75% = \$90.60 85% = \$102.65
13757	THERAPEUTIC VENESESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda Fee: \$64.50 Benefit: 75% = \$48.40 85% = \$54.85

MISCELLANEOUS	INTENSIVE CARE
13760	<p>IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for:</p> <ul style="list-style-type: none"> . chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or . acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogenic bone marrow transplant; or . multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or . small round cell sarcomas; or . primitive neuroectodermal tumour; or . germ cell tumours which have relapsed following, or are refractory to, chemotherapy; . germ cell tumours which have had an incomplete response to first line therapy. <p>- performed under the supervision of a consultant physician - each day.</p> <p>Fee: \$673.90 Benefit: 75% = \$505.45 85% = \$610.00</p>
SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT	
13815	<p>CENTRAL VEIN CATHETERISATION (via jugular, subclavian or femoral vein) by percutaneous or open exposure not being a service to which item 13318 applies (Anaes.)</p> <p>Fee: \$75.35 Benefit: 75% = \$56.55 85% = \$64.05</p>
13818	<p>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)</p> <p>Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45</p>
13830	<p>INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day</p> <p>Fee: \$66.60 Benefit: 75% = \$49.95 85% = \$56.65</p>
13839	<p>ARTERIAL PUNCTURE and collection of blood for diagnostic purposes</p> <p>Fee: \$20.30 Benefit: 75% = \$15.25 85% = \$17.30</p>
13842	<p>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)</p> <p>Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05</p>
13847	<p>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)</p> <p>Fee: \$137.95 Benefit: 75% = \$103.50 85% = \$117.30</p>
13848	<p>COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day subsequent to the first, including associated consultations and monitoring of parameters</p> <p>Fee: \$115.80 Benefit: 75% = \$86.85 85% = \$98.45</p>
13851	<p>CIRCULATORY SUPPORT DEVICE, management of, on first day</p> <p>Fee: \$436.20 Benefit: 75% = \$327.15 85% = \$372.30</p>
13854	<p>CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first</p> <p>Fee: \$101.45 Benefit: 75% = \$76.10 85% = \$86.25</p>
13857	<p>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)</p> <p>Fee: \$129.35 Benefit: 75% = \$97.05 85% = \$109.95</p>

MISCELLANEOUS	CHEMOTHERAPEUTIC
SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT	
<i>(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 <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$320.00 Benefit: 75% = \$240.00 85% = \$272.00
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 <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$237.40 Benefit: 75% = \$178.05 85% = \$201.80
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 <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$67.90 Benefit: 75% = \$50.95 85% = \$57.75
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 <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$129.35 Benefit: 75% = \$97.05 85% = \$109.95
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 <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$101.85 Benefit: 75% = \$76.40 85% = \$86.60
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 <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$135.80 Benefit: 75% = \$101.85 85% = \$115.45
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 <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$67.90 Benefit: 75% = \$50.95 85% = \$57.75
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 or for the administration of drugs used immediately prior to, or with microwave (UHF radiowave) cancer therapy alone <i>(See para T1.10 of explanatory notes to this Category)</i> Fee: \$57.50 Benefit: 75% = \$43.15 85% = \$48.90
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: \$86.50 Benefit: 75% = \$64.90 85% = \$73.55
13921	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment Fee: \$97.90 Benefit: 75% = \$73.45 85% = \$83.25
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: \$57.70 Benefit: 75% = \$43.30 85% = \$49.05

MISCELLANEOUS	DERMATOLOGY
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: \$74.60 Benefit: 75% = \$55.95 85% = \$63.45
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: \$104.10 Benefit: 75% = \$78.10 85% = \$88.50
13933	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20
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: \$75.25 Benefit: 75% = \$56.45 85% = \$64.00
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 <i>(See para T1.11 of explanatory notes to this Category)</i> Fee: \$86.50 Benefit: 75% = \$64.90 85% = \$73.55
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 <i>(See para T1.11 of explanatory notes to this Category)</i> Fee: \$57.70 Benefit: 75% = \$43.30 85% = \$49.05
13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of Fee: \$46.40 Benefit: 75% = \$34.80 85% = \$39.45
13948	CYTOTOXIC AGENT, instillation of, into a body cavity Fee: \$57.70 Benefit: 75% = \$43.30 85% = \$49.05
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 <i>(See para T1.12 of explanatory notes to this Category)</i> Fee: \$46.60 Benefit: 75% = \$34.95 85% = \$39.65
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 <i>(See para T1.12 of explanatory notes to this Category)</i> Fee: \$46.60 Benefit: 75% = \$34.95 85% = \$39.65
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: \$134.75 Benefit: 75% = \$101.10 85% = \$114.55
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.) <i>(See para T1.13 of explanatory notes to this Category)</i> Fee: \$134.75 Benefit: 75% = \$101.10 85% = \$114.55
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.) <i>(See para T1.13 of explanatory notes to this Category)</i> Fee: \$165.50 Benefit: 75% = \$124.15 85% = \$140.70

MISCELLANEOUS	OTHER
14112	<p>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 100cm² and up to 150cm² (Anaes.) (See para T1.13 of explanatory notes to this Category)</p> <p>Fee: \$196.00 Benefit: 75% = \$147.00 85% = \$166.60</p>
14115	<p>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 150cm² and up to 250cm² (Anaes.) (See para T1.13 of explanatory notes to this Category)</p> <p>Fee: \$226.60 Benefit: 75% = \$169.95 85% = \$192.65</p>
14118	<p>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 250cm² (Anaes.) (See para T1.13 of explanatory notes to this Category)</p> <p>Fee: \$287.90 Benefit: 75% = \$215.95 85% = \$244.75</p>
14124	<p>LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of haemangiomas of infancy, including any associated consultation - <i>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</i> (Anaes.) (See para T1.13 of explanatory notes to this Category)</p> <p>Fee: \$134.75 Benefit: 75% = \$101.10 85% = \$114.55</p>
SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES	
14200	<p>GASTRIC LAVAGE in the treatment of ingested poison</p> <p>Fee: \$52.90 Benefit: 75% = \$39.70 85% = \$45.00</p>
14203	<p>HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)</p> <p>Fee: \$45.20 Benefit: 75% = \$33.90 85% = \$38.45</p>
14206	<p>HORMONE OR LIVING TISSUE IMPLANTATION by cannula</p> <p>Fee: \$31.45 Benefit: 75% = \$23.60 85% = \$26.75</p>
14209	<p>INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent</p> <p>Fee: \$78.40 Benefit: 75% = \$58.80 85% = \$66.65</p>
14212	<p>INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.)</p> <p>Fee: \$163.75 Benefit: 75% = \$122.85 85% = \$139.20</p>
14215	<p>LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, accessing of to add or remove fluid</p> <p>Fee: \$86.50 Benefit: 75% = \$64.90 85% = \$73.55</p>
14218	<p>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</p> <p>Fee: \$86.50 Benefit: 75% = \$64.90 85% = \$73.55</p>
14221	<p>LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies</p> <p>Fee: \$46.40 Benefit: 75% = \$34.80 85% = \$39.45</p>
14224	<p>ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)</p> <p>Fee: \$62.20 Benefit: 75% = \$46.65 85% = \$52.90</p>
14227	<p>IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity (See para T1.14 of explanatory notes to this Category)</p> <p>Fee: \$86.50 Benefit: 75% = \$64.90 85% = \$73.55</p>
14230	<p>Intrathecal or epidural SPINAL CATHETER insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (Anaes.) (Assist.) (See para T1.14 of explanatory notes to this Category)</p> <p>Fee: \$263.35 Benefit: 75% = \$197.55</p>

MISCELLANEOUS		OTHER
‡ 14233	INFUSION PUMP, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.) <i>(See para T1.14 of explanatory notes to this Category)</i>	Fee: \$319.80 Benefit: 75% = \$239.85
14236	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion, and connection of pump to catheter and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.) <i>(See para T1.14 of explanatory notes to this Category)</i>	Fee: \$583.15 Benefit: 75% = \$437.40
14239	Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.) <i>(See para T1.14 of explanatory notes to this Category)</i>	Fee: \$140.90 Benefit: 75% = \$105.70
14242	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of severe chronic spasticity (Anaes.) <i>(See para T1.14 of explanatory notes to this Category)</i>	Fee: \$418.55 Benefit: 75% = \$313.95
† 14245	INFLIXIMAB, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where infliximab is provided under section 100 of the Pharmaceutical Benefits Scheme <i>(See para T1.15 of explanatory notes to this Category)</i>	Fee: \$86.50 Benefit: 75% = \$64.90 85% = \$73.55

RADIATION ONCOLOGY		SUPERFICIAL	
GROUP T2 - RADIATION ONCOLOGY			
SUBGROUP 1 - SUPERFICIAL			
<i>(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10)</i>			
15000	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: \$37.60	Benefit: 75% = \$28.20	85% = \$32.00
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 \$15.10		
15006	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field Fee: \$83.40	Benefit: 75% = \$62.55	85% = \$70.90
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 \$16.40		
15012	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye - 1 field Fee: \$47.20	Benefit: 75% = \$35.40	85% = \$40.15
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: \$42.15	Benefit: 75% = \$31.65	85% = \$35.85
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 \$16.65		
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field Fee: \$49.75	Benefit: 75% = \$37.35	85% = \$42.30
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 \$20.05		
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field - 1 field Fee: \$106.25	Benefit: 75% = \$79.70	85% = \$90.35
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 \$41.80		
SUBGROUP 3 - MEGAVOLTAGE			
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field Fee: \$48.35	Benefit: 75% = \$36.30	85% = \$41.10
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 \$28.20		
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: \$52.75	Benefit: 75% = \$39.60	85% = \$44.85
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: \$52.75	Benefit: 75% = \$39.60	85% = \$44.85

RADIATION ONCOLOGY		MEGAVOLTAGE
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: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85	
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: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85	
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: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85	
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 \$33.50	
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 \$33.50	
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 \$33.50	
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 \$33.50	
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 \$33.50	
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: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85	
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: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85	
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: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85	
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: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85	
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: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85	
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 \$33.50	

RADIATION ONCOLOGY		BRACHYTHERAPY
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 \$33.50	
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 \$33.50	
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 \$33.50	
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 \$33.50	
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: \$315.50 Benefit: 75% = \$236.65 85% = \$268.20	
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) Fee: \$315.50 Benefit: 75% = \$236.65 85% = \$268.20	
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: \$598.10 Benefit: 75% = \$448.60 85% = \$534.20	
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: \$598.10 Benefit: 75% = \$448.60 85% = \$534.20	
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30	
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) Fee: \$292.30 Benefit: 75% = \$219.25 85% = \$248.50	
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: \$578.10 Benefit: 75% = \$433.60 85% = \$514.20	
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: \$578.10 Benefit: 75% = \$433.60 85% = \$514.20	
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) Fee: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00	
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) Fee: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00	
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: \$637.95 Benefit: 75% = \$478.50 85% = \$574.05	

RADIATION ONCOLOGY		BRACHYTHERAPY	
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: \$637.95 Benefit: 75% = \$478.50 85% = \$574.05		
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: \$694.10 Benefit: 75% = \$520.60 85% = \$630.20		
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: \$694.10 Benefit: 75% = \$520.60 85% = \$630.20		
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: \$659.00 Benefit: 75% = \$494.25 85% = \$595.10		
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: \$659.00 Benefit: 75% = \$494.25 85% = \$595.10		
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: \$598.10 Benefit: 75% = \$448.60 85% = \$534.20		
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: \$598.10 Benefit: 75% = \$448.60 85% = \$534.20		
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. <i>(See para T2.3 of explanatory notes to this Category)</i> Fee: \$826.70 Benefit: 75% = \$620.05 85% = \$762.80		
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) Fee: \$67.35 Benefit: 75% = \$50.55 85% = \$57.25		
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: \$168.15 Benefit: 75% = \$126.15 85% = \$142.95		
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: \$448.75 Benefit: 75% = \$336.60 85% = \$384.85		
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance Fee: \$51.60 Benefit: 75% = \$38.70 85% = \$43.90		
‡ 15351	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface Fee: \$103.05 Benefit: 75% = \$77.30 85% = \$87.60		
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface Fee: \$125.05 Benefit: 75% = \$93.80 85% = \$106.30		
15357	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 each attendance Fee: \$35.35 Benefit: 75% = \$26.55 85% = \$30.05		

RADIATION ONCOLOGY		COMPUTERISED PLANNING	
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. <i>(See para T2.4 of explanatory notes to this Category)</i>	Fee: \$319.00	Benefit: 75% = \$239.25 85% = \$271.15
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. <i>(See para T2.4 of explanatory notes to this Category)</i>	Fee: \$319.00	Benefit: 75% = \$239.25 85% = \$271.15
SUBGROUP 5 - COMPUTERISED PLANNING			
RADIOTHERAPY PLANNING			
15500	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) <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$214.45	Benefit: 75% = \$160.85 85% = \$182.30
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) <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$275.35	Benefit: 75% = \$206.55 85% = \$234.05
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) <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$411.15	Benefit: 75% = \$308.40 85% = \$349.50
15509	RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies) <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$185.85	Benefit: 75% = \$139.40 85% = \$158.00
15512	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies) <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$239.60	Benefit: 75% = \$179.70 85% = \$203.70
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: \$270.95	Benefit: 75% = \$203.25 85% = \$230.35
15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies) <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$346.80	Benefit: 75% = \$260.10 85% = \$294.80
15518	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$68.00	Benefit: 75% = \$51.00 85% = \$57.80
15521	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$300.35	Benefit: 75% = \$225.30 85% = \$255.30

RADIATION ONCOLOGY		COMPUTERISED PLANNING	
15524	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$563.15	Benefit: 75% = \$422.40 85% = \$499.25
15527	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 <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$69.75	Benefit: 75% = \$52.35 85% = \$59.30
15530	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 <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$311.15	Benefit: 75% = \$233.40 85% = \$264.50
15533	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 <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$590.00	Benefit: 75% = \$442.50 85% = \$526.10
15536	BRACHYTHERAPY PLANNING, computerised radiation dosimetry <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$235.80	Benefit: 75% = \$176.85 85% = \$200.45
15539	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338	Fee: \$554.30	Benefit: 75% = \$415.75 85% = \$490.40
15541	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. <i>(See para T2.4 of explanatory notes to this Category)</i>	Fee: \$235.80	Benefit: 75% = \$176.85 85% = \$200.45
15550	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$581.95	Benefit: 75% = \$436.50 85% = \$518.05
15553	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images <i>(See para T2.2 of explanatory notes to this Category)</i>	Fee: \$627.90	Benefit: 75% = \$470.95 85% = \$564.00

RADIATION ONCOLOGY	STEREOTACTIC RADIOSURGERY
15556	<p>DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where:</p> <p>(a) dosimetry for a single phase three dimensional conformal treatment plan using CT image volume dataset and having a single treatment target volume and organ at risk; and</p> <p>(b) one gross tumour volume or clinical target volume, plus one planning target volume plus at least one relevant organ at risk as defined in the prescription must be rendered as volumes; and</p> <p>(c) the organ at risk must be nominated as a planning dose goal or constraint and the prescription must specify the organ at risk dose goal or constraint; and</p> <p>(d) dose volume histograms must be generated, approved and recorded with the plan; and</p> <p>(e) a CT image volume dataset must be used for the relevant region to be planned and treated; and</p> <p>(f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images</p> <p><i>(See para T2.2 of explanatory notes to this Category)</i></p> <p>Fee: \$587.10 Benefit: 75% = \$440.35 85% = \$523.20</p>
15559	<p>DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where:</p> <p>(a) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, two planning target volumes and one organ at risk defined in the prescription; or</p> <p>(b) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and two organ at risk dose goals or constraints defined in the prescription; or</p> <p>(c) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 1 complexity.</p> <p>All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images</p> <p><i>(See para T2.2 of explanatory notes to this Category)</i></p> <p>Fee: \$765.75 Benefit: 75% = \$574.35 85% = \$701.85</p>
15562	<p>DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where:</p> <p>(a) dosimetry for a three or more phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, three planning target volumes and one organ at risk defined in the prescription; or</p> <p>(b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and</p> <p style="padding-left: 40px;">(i) two planning target volumes; or</p> <p style="padding-left: 40px;">(ii) two organ at risk dose goals or constraints defined in the prescription.</p> <p>or</p> <p>(c) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and three organ at risk dose goals or constraints defined in the prescription;</p> <p>or</p> <p>(d) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity.</p> <p>All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images</p> <p><i>(See para T2.2 of explanatory notes to this Category)</i></p> <p>Fee: \$990.35 Benefit: 75% = \$742.80 85% = \$926.45</p>
SUBGROUP 6 - STEREOTACTIC RADIOSURGERY	
15600	<p>STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment</p> <p>Fee: \$1,504.25 Benefit: 75% = \$1,128.20 85% = \$1,440.35</p>

THERAPEUTIC NUCLEAR MEDICINE		THERAPEUTIC NUCLEAR MEDICINE	
GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE			
16003	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.) <i>(See para T8.8 of explanatory notes to this Category)</i>	Fee: \$574.85	Benefit: 75% = \$431.15 85% = \$510.95
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique	Fee: \$441.75	Benefit: 75% = \$331.35 85% = \$377.85
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique	Fee: \$301.45	Benefit: 75% = \$226.10 85% = \$256.25
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32	Fee: \$260.80	Benefit: 75% = \$195.60 85% = \$221.70
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: \$3,610.30	Benefit: 75% = \$2,707.75 85% = \$3,546.40
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; <u>and</u> 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: \$2,158.20	Benefit: 75% = \$1,618.65 85% = \$2,094.30

OBSTETRICS	OBSTETRICS
GROUP T4 - OBSTETRICS	
ANTENATAL CARE	
	<p>Antenatal service provided by a midwife, nurse or a registered Aboriginal Health Worker if:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner;</p> <p>(b) the service is provided at, or from, a practice location in a regional, rural or remote area RRMA 3-7;</p> <p>(c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day);</p> <p>(d) the service is not provided for an admitted patient of a hospital or approved day facility; and</p> <p>to a maximum of 10 service per pregnancy <i>(See para T4.1 of explanatory notes to this Category)</i></p>
† 16400	Fee: \$21.90 Benefit: 85% = \$18.65
16500	<p>ANTENATAL ATTENDANCE <i>(See para T4.2 of explanatory notes to this Category)</i></p> <p>Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15</p>
16501	<p>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 <i>(See para T4.3 of explanatory notes to this Category)</i></p> <p>Fee: \$124.20 Benefit: 75% = \$93.15 85% = \$105.60</p>
16502	<p>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</p> <p>Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15</p>
16504	<p>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</p> <p>Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15</p>
16505	<p>THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance</p> <p>Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15</p>
16508	<p>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</p> <p>Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15</p>
16509	<p>PREECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of each attendance that is not a routine antenatal attendance</p> <p>Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15</p>
16511	<p>CERVIX, purse string ligation of (Anaes.)</p> <p>Fee: \$194.35 Benefit: 75% = \$145.80 85% = \$165.20</p>
16512	<p>CERVIX, removal of purse string ligature of (Anaes.)</p> <p>Fee: \$56.10 Benefit: 75% = \$42.10 85% = \$47.70</p>
16514	<p>ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)</p> <p>Fee: \$32.40 Benefit: 75% = \$24.30 85% = \$27.55</p>
MANAGEMENT OF LABOUR AND DELIVERY	
16515	<p>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.) <i>(See para T4.4 of explanatory notes to this Category)</i></p> <p>Fee: \$306.30 Benefit: 75% = \$229.75 85% = \$260.40</p>

OBSTETRICS		OBSTETRICS
16518	MANAGEMENT OF LABOUR, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.) (See para T4.4 of explanatory notes to this Category) Fee: \$306.30 Benefit: 75% = \$229.75 85% = \$260.40	
16519	MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.) (See para T4.4 of explanatory notes to this Category) Fee: \$471.65 Benefit: 75% = \$353.75 85% = \$407.75	
16520	CAESAREAN SECTION and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.) (See para T4.5 of explanatory notes to this Category) Fee: \$551.25 Benefit: 75% = \$413.45 85% = \$487.35	
16522	MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days: <ul style="list-style-type: none"> - 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 T4.6 of explanatory notes to this Category) Fee: \$1,107.50 Benefit: 75% = \$830.65 85% = \$1,043.60	
16525	MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.) (See para T4.4 of explanatory notes to this Category) Fee: \$261.25 Benefit: 75% = \$195.95 85% = \$222.10	
POST-PARTUM CARE		
16564	EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$192.60 Benefit: 75% = \$144.45 85% = \$163.75	
16567	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$281.75 Benefit: 75% = \$211.35 85% = \$239.50	
16570	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$367.60 Benefit: 75% = \$275.70 85% = \$312.50	
16571	CERVIX, repair of extensive laceration or lacerations (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$281.75 Benefit: 75% = \$211.35 85% = \$239.50	
16573	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$229.60 Benefit: 75% = \$172.20 85% = \$195.20	

OBSTETRICS		OBSTETRICS
16590	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 Fee: \$114.55 Benefit: 75% = \$85.95 85% = \$97.40	
INTERVENTIONAL TECHNIQUES		
16600	AMNIOCENTESIS, diagnostic <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$56.10 Benefit: 75% = \$42.10 85% = \$47.70	
16603	CHORIONIC VILLUS SAMPLING, by any route <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$107.70 Benefit: 75% = \$80.80 85% = \$91.55	
16606	FETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.) <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$214.90 Benefit: 75% = \$161.20 85% = \$182.70	
16609	FETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.) <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$438.25 Benefit: 75% = \$328.70 85% = \$374.35	
16612	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.) <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$344.80 Benefit: 75% = \$258.60 85% = \$293.10	
16615	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.) <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$183.65 Benefit: 75% = \$137.75 85% = \$156.15	
16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$183.65 Benefit: 75% = \$137.75 85% = \$156.15	
16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$183.65 Benefit: 75% = \$137.75 85% = \$156.15	
16624	FETAL FLUID FILLED CAVITY, drainage of <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70	
16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis <i>(See para T4.8 of explanatory notes to this Category)</i> Fee: \$538.10 Benefit: 75% = \$403.60 85% = \$474.20	
16633	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606, 16609, 16612, 16615 and 16627 <i>(See para T4.8 of explanatory notes to this Category)</i> Derived Fee: 50% of the fee for the first foetus for any additional foetus tested	
16636	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600, 16603, 16618, 16621 and 16624 <i>(See para T4.8 of explanatory notes to this Category)</i> Derived Fee: 50% of the fee for the first foetus for any additional foetus tested	

ANAESTHETICS	CONSULTATIONS
GROUP T6 - ANAESTHETICS	
SUBGROUP 1 - ANAESTHESIA CONSULTATIONS	
ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION	
	(Professional attendance by a medical practitioner in the practice of ANAESTHESIA)
	- a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system)
	- <i>AND of not more than 15 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply (See para T6.1 of explanatory notes to this Category)
† 17610	Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30
	- a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes
	- <i>AND of more than 15 minutes but not more than 30 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 applies (See para T6.1 of explanatory notes to this Category)
† 17615	Fee: \$75.60 Benefit: 75% = \$56.70 85% = \$64.30
	- a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes
	- <i>AND of more than 30 minutes but not more than 45 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply (See para T6.1 of explanatory notes to this Category)
† 17620	Fee: \$104.75 Benefit: 75% = \$78.60 85% = \$89.05
	- a consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems, the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes
	- <i>AND of more than 45 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply (See para T6.1 of explanatory notes to this Category)
† 17625	Fee: \$133.35 Benefit: 75% = \$100.05 85% = \$113.35
ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia)	
	(Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her)
	- a BRIEF consultation involving a short history and limited examination
	- <i>AND of not more than 15 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply (See para T6.2 of explanatory notes to this Category)
† 17640	Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30
	- a consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan
	- <i>AND of more than 15 minutes but not more than 30 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply. (See para T6.2 of explanatory notes to this Category)
† 17645	Fee: \$75.60 Benefit: 75% = \$56.70 85% = \$64.30
	- a consultation involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan
	- <i>AND of more than 30 minutes but not more than 45 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply (See para T6.2 of explanatory notes to this Category)
† 17650	Fee: \$104.75 Benefit: 75% = \$78.60 85% = \$89.05

ANAESTHETICS	CONSULTATIONS
† 17655	<ul style="list-style-type: none"> - a consultation involving an exhaustive history and comprehensive examination of multiple systems and the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity, - <i>AND of more than 45 minutes duration</i>, not being a service associated with a service to which items 2801 – 3000 apply. <i>(See para T6.2 of explanatory notes to this Category)</i> <p>Fee: \$133.35 Benefit: 75% = \$100.05 85% = \$113.35</p>
	<p>ANAESTHETIST, CONSULTATION, OTHER</p> <p>(Professional attendance by an anaesthetist in the practice of ANAESTHESIA)</p>
† 17680	<ul style="list-style-type: none"> - a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 – 3000 apply. <i>(See para T6.3 of explanatory notes to this Category)</i> <p>Fee: \$75.60 Benefit: 75% = \$56.70 85% = \$64.30</p>
† 17690	<ul style="list-style-type: none"> - Where a pre-anaesthesia consultation covered by an item in the range 17615-17625 is performed in-rooms if: <ul style="list-style-type: none"> (a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and (b) the service is not provided to an admitted patient of a hospital or day-hospital facility; and (c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and (d) the service is of more than 15 minutes duration <p>not being a service associated with a service to which items 2801 – 3000 apply. <i>(See para T6.3 of explanatory notes to this Category)</i></p> <p>Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75</p>

REGIONAL OR FIELD NERVE BLOCKS	REGIONAL OR FIELD NERVE BLOCKS
GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS	
18213	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion Fee: \$78.35 Benefit: 75% = \$58.80 85% = \$66.60
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: \$167.75 Benefit: 75% = \$125.85 85% = \$142.60
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 \$16.85 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 <i>(See para T7.2 of explanatory notes to this Category)</i> Fee: \$33.25 Benefit: 75% = \$24.95 85% = \$28.30
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 <i>(See para T7.2 of explanatory notes to this Category)</i> Fee: \$44.25 Benefit: 75% = \$33.20 85% = \$37.65
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. <i>(See para T7.4 of explanatory notes to this Category)</i> Fee: \$251.65 Benefit: 75% = \$188.75 85% = \$213.95
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. <i>(See para T7.4 of explanatory notes to this Category)</i> Derived Fee: The fee for item 18226 plus \$25.25 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: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00
18230	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.) Fee: \$210.70 Benefit: 75% = \$158.05 85% = \$179.10
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.) <i>(See para T7.3 of explanatory notes to this Category)</i> Fee: \$167.75 Benefit: 75% = \$125.85 85% = \$142.60
18233	EPIDURAL INJECTION of blood for blood patch (Anaes.) Fee: \$167.75 Benefit: 75% = \$125.85 85% = \$142.60
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.) <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$110.30 Benefit: 75% = \$82.75 85% = \$93.80
18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.) <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00
18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$33.25 Benefit: 75% = \$24.95 85% = \$28.30
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$82.70 Benefit: 75% = \$62.05 85% = \$70.30

REGIONAL OR FIELD NERVE BLOCKS		REGIONAL OR FIELD NERVE BLOCKS	
18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$33.25 Benefit: 75% = \$24.95 85% = \$28.30		
18244	VAGUS NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$89.05 Benefit: 75% = \$66.80 85% = \$75.70		
18246	GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$89.05 Benefit: 75% = \$66.80 85% = \$75.70		
18248	PHRENIC NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$78.35 Benefit: 75% = \$58.80 85% = \$66.60		
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00		
18252	CERVICAL PLEXUS, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$89.05 Benefit: 75% = \$66.80 85% = \$75.70		
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$89.05 Benefit: 75% = \$66.80 85% = \$75.70		
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00		
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00		
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$78.35 Benefit: 75% = \$58.80 85% = \$66.60		
18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.) <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00		
18264	PUDENDAL NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$89.05 Benefit: 75% = \$66.80 85% = \$75.70		
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 <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00		
18268	OBTURATOR NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$78.35 Benefit: 75% = \$58.80 85% = \$66.60		
18270	FEMORAL NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$78.35 Benefit: 75% = \$58.80 85% = \$66.60		
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i> Fee: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00		

REGIONAL OR FIELD NERVE BLOCKS		REGIONAL OR FIELD NERVE BLOCKS	
18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$78.35	Benefit: 75% = \$58.80 85% = \$66.60
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
18278	SCIATIC NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$78.35	Benefit: 75% = \$58.80 85% = \$66.60
18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.) <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$89.05	Benefit: 75% = \$66.80 85% = \$75.70
18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.) <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$130.50	Benefit: 75% = \$97.90 85% = \$110.95
18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.) <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$130.50	Benefit: 75% = \$97.90 85% = \$110.95
18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.) <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$130.50	Benefit: 75% = \$97.90 85% = \$110.95
18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.)	Fee: \$220.70	Benefit: 75% = \$165.55 85% = \$187.60
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: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)	Fee: \$155.50	Benefit: 75% = \$116.65 85% = \$132.20
18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	Fee: \$133.00	Benefit: 75% = \$99.75 85% = \$113.05
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	Fee: \$155.50	Benefit: 75% = \$116.65 85% = \$132.20

BOTULINUM TOXIN INJECTIONS		BOTULINUM TOXIN INJECTIONS	
GROUP T11 - BOTULINUM TOXIN INJECTIONS			
BOTULINUM TOXIN			
18350	BOTULINUM TOXIN (Botox), injection of, for hemifacial spasm in a patient 12 years of age or older, including all injections on any one day <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
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 <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
18352	BOTULINUM TOXIN (Botox or Dysport), injection of, for cervical dystonia (spasmodic torticollis), including all injections on any one day <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$220.70	Benefit: 75% = \$165.55 85% = \$187.60
18354	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinus foot deformity due to spasticity in an ambulant cerebral palsy patient, between the ages of 2 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.) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
18356	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovarus foot deformity due to spasticity in an ambulant cerebral palsy patient, between the ages of 2 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.) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
18358	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovalgus foot deformity due to spasticity in an ambulant cerebral palsy patient, between the ages of 2 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.) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
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) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
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.) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$218.00	Benefit: 75% = \$163.50 85% = \$185.30
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) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
‡ 18366	BOTULINUM TOXIN (Botox), injection of, for the treatment of strabismus in children and adults, including all such injections on any one day and associated electromyography (Anaes.) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$138.25	Benefit: 75% = \$103.70 85% = \$117.55
‡ 18368	BOTULINUM TOXIN (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$235.95	Benefit: 75% = \$177.00 85% = \$200.60

BOTULINUM TOXIN INJECTIONS		BOTULINUM TOXIN INJECTIONS	
‡ 18370	BOTULINUM TOXIN (Botox), injection of, for the treatment of blepharospasm in a patient 12 years of age or older, including all such injections on any one day. (Anaes.) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$39.80	Benefit: 75% = \$29.85 85% = \$33.85
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.) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$39.80	Benefit: 75% = \$29.85 85% = \$33.85
† 18372	BOTULINUM TOXIN (Botox), injection of, for the treatment of bilateral blepharospasm in a patient 12 years of age or older, including all such injections on any one day (Anaes.) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80
† 18373	BOTULINUM TOXIN (Dysport), injection of, for the treatment of bilateral blepharospasm in a patient 18 years of age or older, including all such injections on any one day (Anaes.) <i>(See para T11 of explanatory notes to this Category)</i>	Fee: \$110.30	Benefit: 75% = \$82.75 85% = \$93.80

RELATIVE VALUE GUIDE		HEAD
GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE		
SUBGROUP 1 - HEAD		
20100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20102	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20104	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20124	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20142	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20143	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20144	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
20145	INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
20146	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20148	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20162	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on the nose and accessory sinuses (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
20164	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20172	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
20174	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units) Fee: \$157.50 Benefit: 75% = \$118.15 85% = \$133.90	

RELATIVE VALUE GUIDE		NECK
20176	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20192	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
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: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
20212	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20214	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units) Fee: \$157.50 Benefit: 75% = \$118.15 85% = \$133.90	
20216	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units) Fee: \$350.00 Benefit: 75% = \$262.50 85% = \$297.50	
20220	INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20222	INITIATION OF MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20225	INITIATION OF MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units) Fee: \$210.00 Benefit: 75% = \$157.50 85% = \$178.50	
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
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: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
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: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20321	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20330	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose and mouth) (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
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: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20352	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	

RELATIVE VALUE GUIDE		INTRATHORACIC	
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
20402	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		
20404	INITIATION OF MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
20405	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast using myocutaneous flaps (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00		
20406	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units) Fee: \$227.50 Benefit: 75% = \$170.65 85% = \$193.40		
20410	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		
20440	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the sternum (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		
20452	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or sternum (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
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: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
20472	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75		
20474	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic units) <i>(See para T10.22 of explanatory notes to this Category)</i> Fee: \$227.50 Benefit: 75% = \$170.65 85% = \$193.40		
SUBGROUP 4 - INTRATHORACIC			
20500	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15		
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: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
20522	INITIATION OF MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		

RELATIVE VALUE GUIDE		SPINE AND SPINAL CORD
20524	INITIATION OF MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20526	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20528	INITIATION OF MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
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: \$227.50 Benefit: 75% = \$170.65 85% = \$193.40	
20542	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
20546	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
20548	INITIATION OF MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea and bronchi (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
20560	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the heart, pericardium or great vessels of chest (20 basic units) Fee: \$350.00 Benefit: 75% = \$262.50 85% = \$297.50	
SUBGROUP 5 - SPINE AND SPINAL CORD		
20600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20604	INITIATION OF MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the patient in the sitting position (13 basic units) Fee: \$227.50 Benefit: 75% = \$170.65 85% = \$193.40	
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: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20622	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic units) Fee: \$227.50 Benefit: 75% = \$170.65 85% = \$193.40	
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: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
20632	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
20634	INITIATION OF MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20670	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord procedures (13 basic units) <i>(See para T10.23 of explanatory notes to this Category)</i> Fee: \$227.50 Benefit: 75% = \$170.65 85% = \$193.40	
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	

RELATIVE VALUE GUIDE		UPPER ABDOMEN
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
20702	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20705	INITIATION OF MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopy procedures (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
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: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20740	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20745	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20752	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20754	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
20756	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units) Fee: \$157.50 Benefit: 75% = \$118.15 85% = \$133.90	
20770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
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: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
20791	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastric reduction or gastroplasty for the treatment of morbid obesity (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20792	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units) Fee: \$227.50 Benefit: 75% = \$170.65 85% = \$193.40	
20793	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
20794	INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units) Fee: \$210.00 Benefit: 75% = \$157.50 85% = \$178.50	

RELATIVE VALUE GUIDE		LOWER ABDOMEN
20798	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20799	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
20802	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20805	INITIATION OF MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopic procedures (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20806	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
20810	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20815	INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20832	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20840	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures within the peritoneal cavity in lower abdomen including appendectomy, not being a service to which another item in this Subgroup applies (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
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: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
20842	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20845	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20846	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	

RELATIVE VALUE GUIDE		PERINEUM
20847	INITIATION OF MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20848	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20850	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units) Fee: \$210.00 Benefit: 75% = \$157.50 85% = \$178.50	
20855	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarian hysterectomy or hysterectomy within 24 hours of delivery. (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
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: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20862	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
20864	INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20866	INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20867	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20868	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient) (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
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: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
20882	INITIATION OF MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
20884	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20886	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
20902	INITIATION OF MANAGEMENT OF ANAESTHESIA for anorectal procedures (including endoscopy and/or biopsy) (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20904	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
20906	INITIATION OF MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	

RELATIVE VALUE GUIDE		PERINEUM
20912	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder tumour(s) (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20914	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
20916	INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
20924	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20926	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20928	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20930	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20932	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20934	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20936	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
20938	INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20942	INITIATION OF MANAGEMENT OF ANAESTHESIA for colpotomy, colpectomy or colpoorrhaphy (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20943	INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20944	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
20946	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal delivery (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
20948	INITIATION OF MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal of purse string ligature (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
20950	INITIATION OF MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
20952	INITIATION OF MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	

RELATIVE VALUE GUIDE		PELVIS
20953	INITIATION OF MANAGEMENT OF ANAESTHESIA for endometrial ablation or resection in association with hysteroscopy (5 basic units) Fee: \$87.50	Benefit: 75% = \$65.65 85% = \$74.40
20954	INITIATION OF MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic units) Fee: \$175.00	Benefit: 75% = \$131.25 85% = \$148.75
20956	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units) Fee: \$70.00	Benefit: 75% = \$52.50 85% = \$59.50
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: \$87.50	Benefit: 75% = \$65.65 85% = \$74.40
20960	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units) Fee: \$122.50	Benefit: 75% = \$91.90 85% = \$104.15
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: \$52.50	Benefit: 75% = \$39.40 85% = \$44.65
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: \$87.50	Benefit: 75% = \$65.65 85% = \$74.40
21112	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) Fee: \$70.00	Benefit: 75% = \$52.50 85% = \$59.50
21114	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units) Fee: \$87.50	Benefit: 75% = \$65.65 85% = \$74.40
21116	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units) Fee: \$105.00	Benefit: 75% = \$78.75 85% = \$89.25
21120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units) Fee: \$105.00	Benefit: 75% = \$78.75 85% = \$89.25
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: \$52.50	Benefit: 75% = \$39.40 85% = \$44.65
21140	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units) Fee: \$262.50	Benefit: 75% = \$196.90 85% = \$223.15
21150	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) Fee: \$175.00	Benefit: 75% = \$131.25 85% = \$148.75
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: \$70.00	Benefit: 75% = \$52.50 85% = \$59.50
21170	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) Fee: \$140.00	Benefit: 75% = \$105.00 85% = \$119.00
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: \$52.50	Benefit: 75% = \$39.40 85% = \$44.65

RELATIVE VALUE GUIDE		KNEE AND POPLITEAL AREA	
21199	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) Fee: \$70.00	Benefit: 75% = \$52.50	85% = \$59.50
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: \$70.00	Benefit: 75% = \$52.50	85% = \$59.50
21202	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4 basic units) Fee: \$70.00	Benefit: 75% = \$52.50	85% = \$59.50
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: \$105.00	Benefit: 75% = \$78.75	85% = \$89.25
21212	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units) Fee: \$175.00	Benefit: 75% = \$131.25	85% = \$148.75
21214	INITIATION OF MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 basic units) Fee: \$175.00	Benefit: 75% = \$131.25	85% = \$148.75
21216	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic units) Fee: \$245.00	Benefit: 75% = \$183.75	85% = \$208.25
21220	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital or day hospital facility (4 basic units) Fee: \$70.00	Benefit: 75% = \$52.50	85% = \$59.50
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: \$105.00	Benefit: 75% = \$78.75	85% = \$89.25
21232	INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units) Fee: \$87.50	Benefit: 75% = \$65.65	85% = \$74.40
21234	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur (8 basic units) Fee: \$140.00	Benefit: 75% = \$105.00	85% = \$119.00
21260	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units) Fee: \$70.00	Benefit: 75% = \$52.50	85% = \$59.50
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: \$140.00	Benefit: 75% = \$105.00	85% = \$119.00
21272	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units) Fee: \$70.00	Benefit: 75% = \$52.50	85% = \$59.50
21274	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units) <i>(See para T10.24 of explanatory notes to this Category)</i> Fee: \$105.00	Benefit: 75% = \$78.75	85% = \$89.25
21280	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg (15 basic units) Fee: \$262.50	Benefit: 75% = \$196.90	85% = \$223.15
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: \$52.50	Benefit: 75% = \$39.40	85% = \$44.65
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: \$70.00	Benefit: 75% = \$52.50	85% = \$59.50

RELATIVE VALUE GUIDE		LOWER LEG
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
21360	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
21382	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
21392	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
21402	INITIATION OF MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
21403	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
21404	INITIATION OF MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
21432	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or popliteal area (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
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: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
21462	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units) Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
21464	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	

RELATIVE VALUE GUIDE	SHOULDER AND AXILLA
21472	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
21474	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50
21482	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower leg, ankle or foot (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
21484	INITIATION OF MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
21486	INITIATION OF MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65
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: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00
21502	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50
21522	INITIATION OF MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
21530	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, ankle or foot (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15
21532	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50
21622	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40

RELATIVE VALUE GUIDE		UPPER ARM AND ELBOW	
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: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
21634	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units) Fee: \$157.50 Benefit: 75% = \$118.15 85% = \$133.90		
21636	INITIATION OF MANAGEMENT OF ANAESTHESIA for interthoroscapular (forequarter) amputation (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15		
21638	INITIATION OF MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75		
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: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00		
21652	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75		
21654	INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00		
21656	INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75		
21670	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
21682	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder spica application when undertaken in a hospital or approved day hospital facility (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
21712	INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		
21714	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		
21716	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
21732	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		

RELATIVE VALUE GUIDE		FOREARM WRIST AND HAND	
21756	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
21760	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15		
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: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00		
21772	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
21790	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15		
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
21832	INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15		
21834	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
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: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00		
21842	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
21870	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, wrist or hand (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15		
21872	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00		

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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
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: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15
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: \$157.50 Benefit: 75% = \$118.15 85% = \$133.90
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: \$192.50 Benefit: 75% = \$144.40 85% = \$163.65
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: \$227.50 Benefit: 75% = \$170.65 85% = \$193.40
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: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15
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: \$297.50 Benefit: 75% = \$223.15 85% = \$252.90
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: \$332.50 Benefit: 75% = \$249.40 85% = \$282.65
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: \$367.50 Benefit: 75% = \$275.65 85% = \$312.40
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65
21906	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
21908	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25
21910	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units) Fee: \$157.50 Benefit: 75% = \$118.15 85% = \$133.90
21912	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: lumbar or thoracic (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40
21914	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25
21915	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40

RELATIVE VALUE GUIDE		ANAESTHESIA
21916	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21918	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21922	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
21925	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
21926	INITIATION OF MANAGEMENT OF ANAESTHESIA for fluoroscopy (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21927	INITIATION OF MANAGEMENT OF ANAESTHESIA for barium enema or other opaque study of the small bowel (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21930	INITIATION OF MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
21935	INITIATION OF MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21936	INITIATION OF MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time transoesophageal examination (6 basic units) <i>(See para T10.26 of explanatory notes to this Category)</i> Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
21939	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic units) Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
21941	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (7 basic units) <i>(See para T10.25 of explanatory notes to this Category)</i> Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
21942	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
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: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21945	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or epidural injection (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21949	INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose of transplantation (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21952	INITIATION OF MANAGEMENT OF ANAESTHESIA for muscle biopsy for malignant hyperpyrexia (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
21955	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21959	INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	

RELATIVE VALUE GUIDE		MISCELLANEOUS
21962	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
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) <i>(See para T10.11 of explanatory notes to this Category)</i> Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
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: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
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: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
21973	INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21976	INITIATION OF MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
21980	INITIATION OF MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
SUBGROUP 18 - MISCELLANEOUS		
21990	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units) <i>(See para T10.12 of explanatory notes to this Category)</i> Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
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: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
21997	INITIATION OF MANAGEMENT OF ANAESTHESIA in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic rebate, not being a service to which item 21992 or 21965 applies where it can be demonstrated that there is a clinical need for anaesthesia (4 basic units) <i>(See para T10.13 of explanatory notes to this Category)</i> Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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) <i>(See para T10.8 of explanatory notes to this Category)</i> Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
22002	ADMINISTRATION OF BLOOD or bone marrow already collected when performed in association with the administration of anaesthesia (4 basic units) <i>(See para T10.8 of explanatory notes to this Category)</i> Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
22007	AWAKE ENDOTRACHEAL INTUBATION with flexible fiberoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
22008	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER , insertion of when performed in association with the administration of anaesthesia (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50	
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) <i>(See para T10.8 of explanatory notes to this Category)</i> Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	

RELATIVE VALUE GUIDE		THERAPEUTIC AND DIAGNOSTIC	
22014	<p>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)</p>	Fee: \$52.50	Benefit: 75% = \$39.40 85% = \$44.65
22015	<p>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)</p>	Fee: \$105.00	Benefit: 75% = \$78.75 85% = \$89.25
22018	<p>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)</p>	Fee: \$122.50	Benefit: 75% = \$91.90 85% = \$104.15
22020	<p>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)</p>	Fee: \$70.00	Benefit: 75% = \$52.50 85% = \$59.50
22025	<p>INTRAARTERIAL CANNULATION when performed in association with the administration of anaesthesia (4 basic units) (See para T10.8 of explanatory notes to this Category)</p>	Fee: \$70.00	Benefit: 75% = \$52.50 85% = \$59.50
22031	<p>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)</p>	Fee: \$87.50	Benefit: 75% = \$65.65 85% = \$74.40
22036	<p>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)</p>	Fee: \$52.50	Benefit: 75% = \$39.40 85% = \$44.65
22040	<p>INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room theatre or recovery room for the control of post operative pain via the femoral OR sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (2 basic units) (See para T10.17 and T10.21 of explanatory notes to this Category)</p>	Fee: \$35.00	Benefit: 75% = \$26.25 85% = \$29.75
22045	<p>INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral AND sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (3 basic units) (See para T10.17 and T10.21 of explanatory notes to this Category)</p>	Fee: \$52.50	Benefit: 75% = \$39.40 85% = \$44.65
22050	<p>INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus in conjunction with shoulder surgery (2 basic units) (See para T10.17 and T10.21 of explanatory notes to this Category)</p>	Fee: \$35.00	Benefit: 75% = \$26.25 85% = \$29.75
22055	<p>PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent (12 basic units)</p>	Fee: \$210.00	Benefit: 75% = \$157.50 85% = \$178.50
22060	<p>WHOLE BODY PERFUSION, CARDIAC BYPASS, using heart-lung machine or equivalent (20 basic units) (See para T10.10 of explanatory notes to this Category)</p>	Fee: \$350.00	Benefit: 75% = \$262.50 85% = \$297.50
22065	<p>INDUCED CONTROLLED HYPOTHERMIA total body (5 basic units) (See para T10.10 of explanatory notes to this Category)</p>	Fee: \$87.50	Benefit: 75% = \$65.65 85% = \$74.40

RELATIVE VALUE GUIDE		ANAESTHESIA FOR DENTAL	
22070	CARDIOPLEGIA , blood or crystalloid, administration by any route (10 basic units) <i>(See para T10.10 of explanatory notes to this Category)</i> Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75		
22075	DEEP HYPOTHERMIC CIRCULATORY ARREST , with core temperature less than 22°C, including management of retrograde cerebral perfusion if performed (15 basic units) <i>(See para T10.10 of explanatory notes to this Category)</i> Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15		
SUBGROUP 20 - ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE			
22900	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) <i>(See para T10.14 of explanatory notes to this Category)</i> Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
22905	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units) <i>(See para T10.14 of explanatory notes to this Category)</i> Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25		
SUBGROUP 21 - ANAESTHESIA/PERFUSION TIME UNITS			
23010	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) <i>(See para T10.3 of explanatory notes to this Category)</i> Fee: \$17.50 Benefit: 75% = \$13.15 85% = \$14.90		
23021	16 MINUTES TO 20 MINUTES (2 basic units) Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75		
23022	21 MINUTES TO 25 MINUTES (2 basic units) Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75		
23023	26 MINUTES TO 30 MINUTES (2 basic units) Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75		
23031	31 MINUTES TO 35 MINUTES (3 basic units) Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
23032	36 MINUTES TO 40 MINUTES (3 basic units) Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
23033	41 MINUTES TO 45 MINUTES (3 basic units) Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
23041	46 MINUTES TO 50 MINUTES (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
23042	51 MINUTES TO 55 MINUTES (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
23043	56 MINUTES TO 1:00 HOUR (4 basic units) Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
23051	1:01 HOURS TO 1:05 HOURS (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		
23052	1:06 HOURS TO 1:10 HOURS (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40		

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
23053	1:11 HOURS TO 1:15 HOURS (5 basic units) Fee: \$87.50 Benefit: 75% = \$65.65 85% = \$74.40	
23061	1:16 HOURS TO 1:20 HOURS (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
23062	1:21 HOURS TO 1:25 HOURS (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
23063	1:26 HOURS TO 1:30 HOURS (6 basic units) Fee: \$105.00 Benefit: 75% = \$78.75 85% = \$89.25	
23071	1:31 HOURS TO 1:35 HOURS (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
23072	1:36 HOURS TO 1:40 HOURS (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
23073	1:41 HOURS TO 1:45 HOURS (7 basic units) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
23081	1:46 HOURS TO 1:50 HOURS (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
23082	1:51 HOURS TO 1:55 HOURS (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
23083	1:56 HOURS TO 2:00 HOURS (8 basic units) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00	
23091	2:01 HOURS TO 2:10 HOURS (9 basic units) Fee: \$157.50 Benefit: 75% = \$118.15 85% = \$133.90	
23101	2:11 HOURS TO 2:20 HOURS (10 basic units) Fee: \$175.00 Benefit: 75% = \$131.25 85% = \$148.75	
23111	2:21 HOURS TO 2:30 HOURS (11 basic units) Fee: \$192.50 Benefit: 75% = \$144.40 85% = \$163.65	
23112	2:31 HOURS TO 2:40 HOURS (12 basic units) Fee: \$210.00 Benefit: 75% = \$157.50 85% = \$178.50	
23113	2:41 HOURS TO 2:50 HOURS (13 basic units) Fee: \$227.50 Benefit: 75% = \$170.65 85% = \$193.40	
23114	2:51 HOURS TO 3:00 HOURS (14 basic units) Fee: \$245.00 Benefit: 75% = \$183.75 85% = \$208.25	
23115	3:01 HOURS TO 3:10 HOURS (15 basic units) Fee: \$262.50 Benefit: 75% = \$196.90 85% = \$223.15	
23116	3:11 HOURS TO 3:20 HOURS (16 basic units) Fee: \$280.00 Benefit: 75% = \$210.00 85% = \$238.00	
23117	3:21 HOURS TO 3:30 HOURS (17 basic units) Fee: \$297.50 Benefit: 75% = \$223.15 85% = \$252.90	
23118	3:31 HOURS TO 3:40 HOURS (18 basic units) Fee: \$315.00 Benefit: 75% = \$236.25 85% = \$267.75	
23119	3:41 HOURS TO 3:50 HOURS (19 basic units) Fee: \$332.50 Benefit: 75% = \$249.40 85% = \$282.65	
23121	3:51 HOURS TO 4:00 HOURS (20 basic units) Fee: \$350.00 Benefit: 75% = \$262.50 85% = \$297.50	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
23170	4:01 HOURS TO 4:10 HOURS (21 basic units) Fee: \$367.50 Benefit: 75% = \$275.65 85% = \$312.40	
23180	4:11 HOURS TO 4:20 HOURS (22 basic units) Fee: \$385.00 Benefit: 75% = \$288.75 85% = \$327.25	
23190	4:21 HOURS TO 4:30 HOURS (23 basic units) Fee: \$402.50 Benefit: 75% = \$301.90 85% = \$342.15	
23200	4:31 HOURS TO 4:40 HOURS (24 basic units) Fee: \$420.00 Benefit: 75% = \$315.00 85% = \$357.00	
23210	4:41 HOURS TO 4:50 HOURS (25 basic units) Fee: \$437.50 Benefit: 75% = \$328.15 85% = \$373.60	
23220	4:51 HOURS TO 5:00 HOURS (26 basic units) Fee: \$455.00 Benefit: 75% = \$341.25 85% = \$391.10	
23230	5:01 HOURS TO 5:10 HOURS (27 basic units) Fee: \$472.50 Benefit: 75% = \$354.40 85% = \$408.60	
23240	5:11 HOURS TO 5:20 HOURS (28 basic units) Fee: \$490.00 Benefit: 75% = \$367.50 85% = \$426.10	
23250	5:21 HOURS TO 5:30 HOURS (29 basic units) Fee: \$507.50 Benefit: 75% = \$380.65 85% = \$443.60	
23260	5:31 HOURS TO 5:40 HOURS (30 basic units) Fee: \$525.00 Benefit: 75% = \$393.75 85% = \$461.10	
23270	5:41 HOURS TO 5:50 HOURS (31 basic units) Fee: \$542.50 Benefit: 75% = \$406.90 85% = \$478.60	
23280	(5:51 HOURS TO 6:00 HOURS (32 basic units) Fee: \$560.00 Benefit: 75% = \$420.00 85% = \$496.10	
23290	6:01 HOURS TO 6:10 HOURS (33 basic units) Fee: \$577.50 Benefit: 75% = \$433.15 85% = \$513.60	
23300	6:11 HOURS TO 6:20 HOURS (34 basic units) Fee: \$595.00 Benefit: 75% = \$446.25 85% = \$531.10	
23310	6:21 HOURS TO 6:30 HOURS (35 basic units) Fee: \$612.50 Benefit: 75% = \$459.40 85% = \$548.60	
23320	6:31 HOURS TO 6:40 HOURS (36 basic units) Fee: \$630.00 Benefit: 75% = \$472.50 85% = \$566.10	
23330	6:41 HOURS TO 6:50 HOURS (37 basic units) Fee: \$647.50 Benefit: 75% = \$485.65 85% = \$583.60	
23340	6:51 HOURS TO 7:00 HOURS (38 basic units) Fee: \$665.00 Benefit: 75% = \$498.75 85% = \$601.10	
23350	7:01 HOURS TO 7:10 HOURS (39 basic units) Fee: \$682.50 Benefit: 75% = \$511.90 85% = \$618.60	
23360	7:11 HOURS TO 7:20 HOURS (40 basic units) Fee: \$700.00 Benefit: 75% = \$525.00 85% = \$636.10	
23370	7:21 HOURS TO 7:30 HOURS (41 basic units) Fee: \$717.50 Benefit: 75% = \$538.15 85% = \$653.60	
23380	7:31 HOURS TO 7:40 HOURS (42 basic units) Fee: \$735.00 Benefit: 75% = \$551.25 85% = \$671.10	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS	
23390	7:41 HOURS TO 7:50 HOURS (43 basic units) Fee: \$752.50 Benefit: 75% = \$564.40 85% = \$688.60		
23400	7:51 HOURS TO 8:00 HOURS (44 basic units) Fee: \$770.00 Benefit: 75% = \$577.50 85% = \$706.10		
23410	8:01 HOURS TO 8:10 HOURS (45 basic units) Fee: \$787.50 Benefit: 75% = \$590.65 85% = \$723.60		
23420	8:11 HOURS TO 8:20 HOURS (46 basic units) Fee: \$805.00 Benefit: 75% = \$603.75 85% = \$741.10		
23430	8:21 HOURS TO 8:30 HOURS (47 basic units) Fee: \$822.50 Benefit: 75% = \$616.90 85% = \$758.60		
23440	8:31 HOURS TO 8:40 HOURS (48 basic units) Fee: \$840.00 Benefit: 75% = \$630.00 85% = \$776.10		
23450	8:41 HOURS TO 8:50 HOURS (49 basic units) Fee: \$857.50 Benefit: 75% = \$643.15 85% = \$793.60		
23460	8:51 HOURS TO 9:00 HOURS (50 basic units) Fee: \$875.00 Benefit: 75% = \$656.25 85% = \$811.10		
23470	9:01 HOURS TO 9:10 HOURS (51 basic units) Fee: \$892.50 Benefit: 75% = \$669.40 85% = \$828.60		
23480	9:11 HOURS TO 9:20 HOURS (52 basic units) Fee: \$910.00 Benefit: 75% = \$682.50 85% = \$846.10		
23490	9:21 HOURS TO 9:30 HOURS (53 basic units) Fee: \$927.50 Benefit: 75% = \$695.65 85% = \$863.60		
23500	9:31 HOURS TO 9:40 HOURS (54 basic units) Fee: \$945.00 Benefit: 75% = \$708.75 85% = \$881.10		
23510	9:41 HOURS TO 9:50 HOURS (55 basic units) Fee: \$962.50 Benefit: 75% = \$721.90 85% = \$898.60		
23520	9:51 HOURS TO 10:00 HOURS (56 basic units) Fee: \$980.00 Benefit: 75% = \$735.00 85% = \$916.10		
23530	10:01 HOURS TO 10:10 HOURS (57 basic units) Fee: \$997.50 Benefit: 75% = \$748.15 85% = \$933.60		
23540	10:11 HOURS TO 10:20 HOURS (58 basic units) Fee: \$1,015.00 Benefit: 75% = \$761.25 85% = \$951.10		
23550	10:21 HOURS TO 10:30 HOURS (59 basic units) Fee: \$1,032.50 Benefit: 75% = \$774.40 85% = \$968.60		
23560	10:31 HOURS TO 10:40 HOURS (60 basic units) Fee: \$1,050.00 Benefit: 75% = \$787.50 85% = \$986.10		
23570	10:41 HOURS TO 10:50 HOURS (61 basic units) Fee: \$1,067.50 Benefit: 75% = \$800.65 85% = \$1,003.60		
23580	10:51 HOURS TO 11:00 HOURS (62 basic units) Fee: \$1,085.00 Benefit: 75% = \$813.75 85% = \$1,021.10		
23590	11:01 HOURS TO 11:10 HOURS (63 basic units) Fee: \$1,102.50 Benefit: 75% = \$826.90 85% = \$1,038.60		
23600	11:11 HOURS TO 11:20 HOURS (64 basic units) Fee: \$1,120.00 Benefit: 75% = \$840.00 85% = \$1,056.10		

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
23610	11:21 HOURS TO 11:30 HOURS (65 basic units) Fee: \$1,137.50 Benefit: 75% = \$853.15 85% = \$1,073.60	
23620	11:31 HOURS TO 11:40 HOURS (66 basic units) Fee: \$1,155.00 Benefit: 75% = \$866.25 85% = \$1,091.10	
23630	11:41 HOURS TO 11:50 HOURS (67 basic units) Fee: \$1,172.50 Benefit: 75% = \$879.40 85% = \$1,108.60	
23640	11:51 HOURS TO 12:00 HOURS (68 basic units) Fee: \$1,190.00 Benefit: 75% = \$892.50 85% = \$1,126.10	
23650	12:01 HOURS TO 12:10 HOURS (69 basic units) Fee: \$1,207.50 Benefit: 75% = \$905.65 85% = \$1,143.60	
23660	12:11 HOURS TO 12:20 HOURS (70 basic units) Fee: \$1,225.00 Benefit: 75% = \$918.75 85% = \$1,161.10	
23670	12:21 HOURS TO 12:30 HOURS (71 basic units) Fee: \$1,242.50 Benefit: 75% = \$931.90 85% = \$1,178.60	
23680	12:31 HOURS TO 12:40 HOURS (72 basic units) Fee: \$1,260.00 Benefit: 75% = \$945.00 85% = \$1,196.10	
23690	12:41 HOURS TO 12:50 HOURS (73 basic units) Fee: \$1,277.50 Benefit: 75% = \$958.15 85% = \$1,213.60	
23700	12:51 HOURS TO 13:00 HOURS (74 basic units) Fee: \$1,295.00 Benefit: 75% = \$971.25 85% = \$1,231.10	
23710	13:01 HOURS TO 13:10 HOURS (75 basic units) Fee: \$1,312.50 Benefit: 75% = \$984.40 85% = \$1,248.60	
23720	13:11 HOURS TO 13:20 HOURS (76 basic units) Fee: \$1,330.00 Benefit: 75% = \$997.50 85% = \$1,266.10	
23730	13:21 HOURS TO 13:30 HOURS (77 basic units) Fee: \$1,347.50 Benefit: 75% = \$1,010.65 85% = \$1,283.60	
23740	13:31 HOURS TO 13:40 HOURS (78 basic units) Fee: \$1,365.00 Benefit: 75% = \$1,023.75 85% = \$1,301.10	
23750	13:41 HOURS TO 13:50 HOURS (79 basic units) Fee: \$1,382.50 Benefit: 75% = \$1,036.90 85% = \$1,318.60	
23760	13:51 HOURS TO 14:00 HOURS (80 basic units) Fee: \$1,400.00 Benefit: 75% = \$1,050.00 85% = \$1,336.10	
23770	14:01 HOURS TO 14:10 HOURS (81 basic units) Fee: \$1,417.50 Benefit: 75% = \$1,063.15 85% = \$1,353.60	
23780	14:11 HOURS TO 14:20 HOURS (82 basic units) Fee: \$1,435.00 Benefit: 75% = \$1,076.25 85% = \$1,371.10	
23790	14:21 HOURS TO 14:30 HOURS (83 basic units) Fee: \$1,452.50 Benefit: 75% = \$1,089.40 85% = \$1,388.60	
23800	14:31 HOURS TO 14:40 HOURS (84 basic units) Fee: \$1,470.00 Benefit: 75% = \$1,102.50 85% = \$1,406.10	
23810	14:41 HOURS TO 14:50 HOURS (85 basic units) Fee: \$1,487.50 Benefit: 75% = \$1,115.65 85% = \$1,423.60	
23820	14:51 HOURS TO 15:00 HOURS (86 basic units) Fee: \$1,505.00 Benefit: 75% = \$1,128.75 85% = \$1,441.10	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
23830	15:01 HOURS TO 15:10 HOURS (87 basic units) Fee: \$1,522.50 Benefit: 75% = \$1,141.90 85% = \$1,458.60	
23840	15:11 HOURS TO 15:20 HOURS (88 basic units) Fee: \$1,540.00 Benefit: 75% = \$1,155.00 85% = \$1,476.10	
23850	15:21 HOURS TO 15:30 HOURS (89 basic units) Fee: \$1,557.50 Benefit: 75% = \$1,168.15 85% = \$1,493.60	
23860	15:31 HOURS TO 15:40 HOURS (90 basic units) Fee: \$1,575.00 Benefit: 75% = \$1,181.25 85% = \$1,511.10	
23870	15:41 HOURS TO 15:50 HOURS (91 basic units) Fee: \$1,592.50 Benefit: 75% = \$1,194.40 85% = \$1,528.60	
23880	15:51 HOURS TO 16:00 HOURS (92 basic units) Fee: \$1,610.00 Benefit: 75% = \$1,207.50 85% = \$1,546.10	
23890	16:01 HOURS TO 16:10 HOURS (93 basic units) Fee: \$1,627.50 Benefit: 75% = \$1,220.65 85% = \$1,563.60	
23900	16:11 HOURS TO 16:20 HOURS (94 basic units) Fee: \$1,645.00 Benefit: 75% = \$1,233.75 85% = \$1,581.10	
23910	16:21 HOURS TO 16:30 HOURS (95 basic units) Fee: \$1,662.50 Benefit: 75% = \$1,246.90 85% = \$1,598.60	
23920	16:31 HOURS TO 16:40 HOURS (96 basic units) Fee: \$1,680.00 Benefit: 75% = \$1,260.00 85% = \$1,616.10	
23930	16:41 HOURS TO 16:50 HOURS (97 basic units) Fee: \$1,697.50 Benefit: 75% = \$1,273.15 85% = \$1,633.60	
23940	16:51 HOURS TO 17:00 HOURS (98 basic units) Fee: \$1,715.00 Benefit: 75% = \$1,286.25 85% = \$1,651.10	
23950	17:01 HOURS TO 17:10 HOURS (99 basic units) Fee: \$1,732.50 Benefit: 75% = \$1,299.40 85% = \$1,668.60	
23960	17:11 HOURS TO 17:20 HOURS (100 basic units) Fee: \$1,750.00 Benefit: 75% = \$1,312.50 85% = \$1,686.10	
23970	17:21 HOURS TO 17:30 HOURS (101 basic units) Fee: \$1,767.50 Benefit: 75% = \$1,325.65 85% = \$1,703.60	
23980	17:31 HOURS TO 17:40 HOURS (102 basic units) Fee: \$1,785.00 Benefit: 75% = \$1,338.75 85% = \$1,721.10	
23990	17:41 HOURS TO 17:50 HOURS (103 basic units) Fee: \$1,802.50 Benefit: 75% = \$1,351.90 85% = \$1,738.60	
24100	17:51 HOURS TO 18:00 HOURS (104 basic units) Fee: \$1,820.00 Benefit: 75% = \$1,365.00 85% = \$1,756.10	
24101	18:01 HOURS TO 18:10 HOURS (105 basic units) Fee: \$1,837.50 Benefit: 75% = \$1,378.15 85% = \$1,773.60	
24102	18:11 HOURS TO 18:20 HOURS (106 basic units) Fee: \$1,855.00 Benefit: 75% = \$1,391.25 85% = \$1,791.10	
24103	18:21 HOURS TO 18:30 HOURS (107 basic units) Fee: \$1,872.50 Benefit: 75% = \$1,404.40 85% = \$1,808.60	
24104	18:31 HOURS TO 18:40 HOURS (108 basic units) Fee: \$1,890.00 Benefit: 75% = \$1,417.50 85% = \$1,826.10	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
24105	18:41 HOURS TO 18:50 HOURS (109 basic units) Fee: \$1,907.50 Benefit: 75% = \$1,430.65 85% = \$1,843.60	
24106	18:51 HOURS TO 19:00 HOURS (110 basic units) Fee: \$1,925.00 Benefit: 75% = \$1,443.75 85% = \$1,861.10	
24107	19:01 HOURS TO 19:10 HOURS (111 basic units) Fee: \$1,942.50 Benefit: 75% = \$1,456.90 85% = \$1,878.60	
24108	19:11 HOURS TO 19:20 HOURS (112 basic units) Fee: \$1,960.00 Benefit: 75% = \$1,470.00 85% = \$1,896.10	
24109	19:21 HOURS TO 19:30 HOURS (113 basic units) Fee: \$1,977.50 Benefit: 75% = \$1,483.15 85% = \$1,913.60	
24110	19:31 HOURS TO 19:40 HOURS (114 basic units) Fee: \$1,995.00 Benefit: 75% = \$1,496.25 85% = \$1,931.10	
24111	19:41 HOURS TO 19:50 HOURS (115 basic units) Fee: \$2,012.50 Benefit: 75% = \$1,509.40 85% = \$1,948.60	
24112	19:51 HOURS TO 20:00 HOURS (116 basic units) Fee: \$2,030.00 Benefit: 75% = \$1,522.50 85% = \$1,966.10	
24113	20:01 HOURS TO 20:10 HOURS (117 basic units) Fee: \$2,047.50 Benefit: 75% = \$1,535.65 85% = \$1,983.60	
24114	20:11 HOURS TO 20:20 HOURS (118 basic units) Fee: \$2,065.00 Benefit: 75% = \$1,548.75 85% = \$2,001.10	
24115	20:21 HOURS TO 20:30 HOURS (119 basic units) Fee: \$2,082.50 Benefit: 75% = \$1,561.90 85% = \$2,018.60	
24116	20:31 HOURS TO 20:40 HOURS (120 basic units) Fee: \$2,100.00 Benefit: 75% = \$1,575.00 85% = \$2,036.10	
24117	20:41 HOURS TO 20:50 HOURS (121 basic units) Fee: \$2,117.50 Benefit: 75% = \$1,588.15 85% = \$2,053.60	
24118	20:51 HOURS TO 21:00 HOURS (122 basic units) Fee: \$2,135.00 Benefit: 75% = \$1,601.25 85% = \$2,071.10	
24119	21:01 HOURS TO 21:10 HOURS (123 basic units) Fee: \$2,152.50 Benefit: 75% = \$1,614.40 85% = \$2,088.60	
24120	21:11 HOURS TO 21:20 HOURS (124 basic units) Fee: \$2,170.00 Benefit: 75% = \$1,627.50 85% = \$2,106.10	
24121	21:21 HOURS TO 21:30 HOURS (125 basic units) Fee: \$2,187.50 Benefit: 75% = \$1,640.65 85% = \$2,123.60	
24122	21:31 HOURS TO 21:40 HOURS (126 basic units) Fee: \$2,205.00 Benefit: 75% = \$1,653.75 85% = \$2,141.10	
24123	21:41 HOURS TO 21:50 HOURS (127 basic units) Fee: \$2,222.50 Benefit: 75% = \$1,666.90 85% = \$2,158.60	
24124	21:51 HOURS TO 22:00 HOURS (128 basic units) Fee: \$2,240.00 Benefit: 75% = \$1,680.00 85% = \$2,176.10	
24125	22:01 HOURS TO 22:10 HOURS (129 basic units) Fee: \$2,257.50 Benefit: 75% = \$1,693.15 85% = \$2,193.60	
24126	22:11 HOURS TO 22:20 HOURS (130 basic units) Fee: \$2,275.00 Benefit: 75% = \$1,706.25 85% = \$2,211.10	

RELATIVE VALUE GUIDE		ANAESTHESIA MODIFYING UNITS	
24127	22:21 HOURS TO 22:30 HOURS (131 basic units) Fee: \$2,292.50 Benefit: 75% = \$1,719.40 85% = \$2,228.60		
24128	22:31 HOURS TO 22:40 HOURS (132 basic units) Fee: \$2,310.00 Benefit: 75% = \$1,732.50 85% = \$2,246.10		
24129	22:41 HOURS TO 22:50 HOURS (133 basic units) Fee: \$2,327.50 Benefit: 75% = \$1,745.65 85% = \$2,263.60		
24130	22:51 HOURS TO 23:00 HOURS (134 basic units) Fee: \$2,345.00 Benefit: 75% = \$1,758.75 85% = \$2,281.10		
24131	23:01 HOURS TO 23:10 HOURS (135 basic units) Fee: \$2,362.50 Benefit: 75% = \$1,771.90 85% = \$2,298.60		
24132	23:11 HOURS TO 23:20 HOURS (136 basic units) Fee: \$2,380.00 Benefit: 75% = \$1,785.00 85% = \$2,316.10		
24133	23:21 HOURS TO 23:30 HOURS (137 basic units) Fee: \$2,397.50 Benefit: 75% = \$1,798.15 85% = \$2,333.60		
24134	23:31 HOURS TO 23:40 HOURS (138 basic units) Fee: \$2,415.00 Benefit: 75% = \$1,811.25 85% = \$2,351.10		
24135	23:41 HOURS TO 23:50 HOURS (139 basic units) Fee: \$2,432.50 Benefit: 75% = \$1,824.40 85% = \$2,368.60		
24136	23:51 HOURS TO 24:00 HOURS (140 basic units) Fee: \$2,450.00 Benefit: 75% = \$1,837.50 85% = \$2,386.10		
SUBGROUP 22 - ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS			
ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA (a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units) (See para T10.3 of explanatory notes to this Category)			
25000	Fee: \$17.50 Benefit: 75% = \$13.15 85% = \$14.90		
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: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75		
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: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65		
SUBGROUP 23 - ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER			
ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient is less than 12 months of age or 70 years or greater (1 basic units)			
25015	Fee: \$17.50 Benefit: 75% = \$13.15 85% = \$14.90		
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)			
25020	Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75		

RELATIVE VALUE GUIDE	PERFUSION MODIFIER
SUBGROUP 24 - ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER	
25025	<p>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)</p> <p>Derived Fee: An additional amount of 50% of the fee for the anaesthetic service. That is:</p> <ul style="list-style-type: none"> (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	<p>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)</p> <p>Derived Fee: An additional amount of 50% of the fee for assistance at anaesthesia. That is:</p> <ul style="list-style-type: none"> (a) an assistant anaesthesia item in the range 25200 - 25205 plus, (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-25015 (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22050
SUBGROUP 25 - PERFUSION AFTER HOURS EMERGENCY MODIFIER	
25050	<p>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)</p> <p>Derived Fee: An additional amount of 50% of the fee for the perfusion service. That is:</p> <ul style="list-style-type: none"> (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	<p>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)</p> <p>Derived Fee: An amount of \$87.50 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable, an item in the range 25000 - 25020</p>
25205	<p>ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA where:</p> <ul style="list-style-type: none"> (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 <p>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)</p> <p>Derived Fee: An amount of \$87.50 (5 basic units), plus an item in the range 23010 - 24136, plus, where applicable, an item in the range 25000 -25020</p>

OPERATIONS	GENERAL
GROUP T8 - SURGICAL OPERATIONS	
SUBGROUP 1 - GENERAL	
30001	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds <i>(See para T8.9 of explanatory notes to this Category)</i> Derived Fee: 50% of the fee which would have applied had the procedure not been discontinued
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation Fee: \$32.10 Benefit: 75% = \$24.10 85% = \$27.30
30006	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation Fee: \$41.10 Benefit: 75% = \$30.85 85% = \$34.95
30009 G 30010 S	LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) Fee: \$53.65 Benefit: 75% = \$40.25 Fee: \$65.30 Benefit: 75% = \$49.00
30013 G 30014 S	EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) Fee: \$115.65 Benefit: 75% = \$86.75 Fee: \$137.30 Benefit: 75% = \$103.00
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: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90
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: \$561.10 Benefit: 75% = \$420.85
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.) <i>(See para T8.10 of explanatory notes to this Category)</i> Fee: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90
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: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) <i>(See para T8.10 of explanatory notes to this Category)</i> Fee: \$46.15 Benefit: 75% = \$34.65 85% = \$39.25
30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) <i>(See para T8.10 of explanatory notes to this Category)</i> Fee: \$79.50 Benefit: 75% = \$59.65 85% = \$67.60
30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) <i>(See para T8.10 of explanatory notes to this Category)</i> Fee: \$72.90 Benefit: 75% = \$54.70 85% = \$62.00
30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) <i>(See para T8.10 of explanatory notes to this Category)</i> Fee: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30

OPERATIONS		GENERAL
30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) (See para T8.10 of explanatory notes to this Category) Fee: \$79.50 Benefit: 75% = \$59.65 85% = \$67.60	
30041 G 30042 S	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) (See para T8.10 of explanatory notes to this Category) Fee: \$127.25 Benefit: 75% = \$95.45 85% = \$108.20 Fee: \$164.05 Benefit: 75% = \$123.05 85% = \$139.45	
30045	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) (See para T8.10 of explanatory notes to this Category) Fee: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30	
30048 G 30049 S	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) (See para T8.10 of explanatory notes to this Category) Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50 Fee: \$164.05 Benefit: 75% = \$123.05 85% = \$139.45	
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) Fee: \$224.40 Benefit: 75% = \$168.30 85% = \$190.75	
30055	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.) Fee: \$65.30 Benefit: 75% = \$49.00 85% = \$55.55	
30058	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.) Fee: \$127.25 Benefit: 75% = \$95.45 85% = \$108.20	
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.) Fee: \$20.75 Benefit: 75% = \$15.60 85% = \$17.65	
30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.) Fee: \$97.10 Benefit: 75% = \$72.85 85% = \$82.55	
30067 G 30068 S	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) Fee: \$197.60 Benefit: 75% = \$148.20 85% = \$168.00 Fee: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90	
30071	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) Fee: \$46.15 Benefit: 75% = \$34.65 85% = \$39.25	
30074 G 30075 S	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) Fee: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30 Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50	
30078	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) Fee: \$42.80 Benefit: 75% = \$32.10 85% = \$36.40	
30081	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) Fee: \$97.10 Benefit: 75% = \$72.85 85% = \$82.55	

OPERATIONS		GENERAL
30084	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.) <i>(See para T8.11 of explanatory notes to this Category)</i> Fee: \$51.95 Benefit: 75% = \$39.00 85% = \$44.20	
30087	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.) <i>(See para T8.11 of explanatory notes to this Category)</i> Fee: \$26.05 Benefit: 75% = \$19.55 85% = \$22.15	
30090	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.) <i>(See para T8.11 of explanatory notes to this Category)</i> Fee: \$113.60 Benefit: 75% = \$85.20 85% = \$96.60	
30093	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.) <i>(See para T8.11 of explanatory notes to this Category)</i> Fee: \$151.60 Benefit: 75% = \$113.70 85% = \$128.90	
30094	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.) <i>(See para T8.11 of explanatory notes to this Category)</i> Fee: \$167.35 Benefit: 75% = \$125.55 85% = \$142.25	
30096	DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for pathological examination (Anaes.) <i>(See para T8.11 of explanatory notes to this Category)</i> Fee: \$162.50 Benefit: 75% = \$121.90 85% = \$138.15	
† 30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented. Fee: \$85.90 Benefit: 75% = \$64.45 85% = \$73.05	
30099	SINUS, excision of, involving superficial tissue only (Anaes.) Fee: \$79.50 Benefit: 75% = \$59.65 85% = \$67.60	
30102 G 30103 S	SINUS, excision of, involving muscle and deep tissue (Anaes.) Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50 Fee: \$162.50 Benefit: 75% = \$121.90 85% = \$138.15	
30104	PRE-AURICULAR SINUS, excision of (Anaes.) Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35	
30106 G 30107 S	GANGLION OR SMALL BURSA, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$137.30 Benefit: 75% = \$103.00 85% = \$116.75 Fee: \$194.35 Benefit: 75% = \$145.80 85% = \$165.20	
30110 G 30111 S	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.) (Assist.) Fee: \$251.25 Benefit: 75% = \$188.45 85% = \$213.60 Fee: \$328.30 Benefit: 75% = \$246.25 85% = \$279.10	
30114	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.) Fee: \$328.30 Benefit: 75% = \$246.25	
30165	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.) <i>(See para T8.12 of explanatory notes to this Category)</i> Fee: \$401.90 Benefit: 75% = \$301.45 85% = \$341.65	
30168	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.) <i>(See para T8.12 of explanatory notes to this Category)</i> Fee: \$401.90 Benefit: 75% = \$301.45 85% = \$341.65	

OPERATIONS	GENERAL
30171	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.) <i>(See para T8.12 of explanatory notes to this Category)</i> Fee: \$611.30 Benefit: 75% = \$458.50 85% = \$547.40
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.) <i>(See para T8.12 of explanatory notes to this Category)</i> Fee: \$611.30 Benefit: 75% = \$458.50 85% = \$547.40
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.) <i>(See para T8.12 of explanatory notes to this Category)</i> Fee: \$871.05 Benefit: 75% = \$653.30
30180	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.) Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55
30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.) Fee: \$217.80 Benefit: 75% = \$163.35 85% = \$185.15
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.) <i>(See para T8.13 of explanatory notes to this Category)</i> Fee: \$161.25 Benefit: 75% = \$120.95 85% = \$137.10
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.) <i>(See para T8.13 of explanatory notes to this Category)</i> Fee: \$41.95 Benefit: 75% = \$31.50 85% = \$35.70
30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital or day-hospital facility, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.) <i>(See para T8.13 of explanatory notes to this Category)</i> Fee: \$227.05 Benefit: 75% = \$170.30 85% = \$193.00
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.) <i>(See para T8.13 of explanatory notes to this Category)</i> Fee: \$130.15 Benefit: 75% = \$97.65 85% = \$110.65
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: \$351.50 Benefit: 75% = \$263.65 85% = \$298.80
30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) <i>(See para T8.13 of explanatory notes to this Category)</i> Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75
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.) <i>(See para T8.13 of explanatory notes to this Category)</i> Fee: \$56.10 Benefit: 75% = \$42.10 85% = \$47.70
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.) <i>(See para T8.14 of explanatory notes to this Category)</i> Fee: \$111.60 Benefit: 75% = \$83.70 85% = \$94.90

OPERATIONS	GENERAL
30197	<p>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.) <i>(See para T8.14 of explanatory notes to this Category)</i> Fee: \$388.85 Benefit: 75% = \$291.65 85% = \$330.55</p>
30202	<p>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 <i>(See para T8.14 of explanatory notes to this Category)</i> Fee: \$42.70 Benefit: 75% = \$32.05 85% = \$36.30</p>
30203	<p>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) <i>(See para T8.14 of explanatory notes to this Category)</i> Fee: \$150.45 Benefit: 75% = \$112.85 85% = \$127.90</p>
30205	<p>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: \$111.60 Benefit: 75% = \$83.70 85% = \$94.90</p>
30207	<p>SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (Anaes.) Fee: \$39.40 Benefit: 75% = \$29.55 85% = \$33.50</p>
30210	<p>KELOID and other SKIN LESIONS, EXTENSIVE, MULTIPLE INJECTIONS OF HYDROCORTISONE or similar preparations where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$144.00 Benefit: 75% = \$108.00 85% = \$122.40</p>
30213	<p>TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes.) <i>(See para T8.15 of explanatory notes to this Category)</i> Fee: \$97.00 Benefit: 75% = \$72.75 85% = \$82.45</p>
30214	<p>TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - session of at least 20 minutes duration - where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period <i>(See para T8.15 of explanatory notes to this Category)</i> Fee: \$97.00 Benefit: 75% = \$72.75 85% = \$82.45</p>
30216	<p>HAEMATOMA, aspiration of (Anaes.) Fee: \$24.15 Benefit: 75% = \$18.15 85% = \$20.55</p>
30219	<p>HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital or day-hospital facility - INCISION WITH DRAINAGE OF (excluding aftercare) Fee: \$24.15 Benefit: 75% = \$18.15 85% = \$20.55</p>
30223	<p>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: \$144.00 Benefit: 75% = \$108.00</p>
30224	<p>PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$209.95 Benefit: 75% = \$157.50 85% = \$178.50</p>
30225	<p>ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$236.50 Benefit: 75% = \$177.40 85% = \$201.05</p>
30226	<p>MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.) Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50</p>
30229	<p>MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.) Fee: \$241.20 Benefit: 75% = \$180.90 85% = \$205.05</p>
30232	<p>MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) Fee: \$197.60 Benefit: 75% = \$148.20 85% = \$168.00</p>

OPERATIONS		GENERAL
30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95 85% = \$222.10	
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50	
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20 85% = \$267.70	
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20	
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) Fee: \$609.55 Benefit: 75% = \$457.20	
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.) Fee: \$653.30 Benefit: 75% = \$490.00	
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.) Fee: \$1,105.50 Benefit: 75% = \$829.15	
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.) Fee: \$1,698.10 Benefit: 75% = \$1,273.60 85% = \$1,634.20	
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.) Fee: \$737.05 Benefit: 75% = \$552.80	
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) Fee: \$981.45 Benefit: 75% = \$736.10	
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) Fee: \$393.60 Benefit: 75% = \$295.20	
30259	SUBLINGUAL GLAND, extirpation of (Anaes.) Fee: \$174.20 Benefit: 75% = \$130.65 85% = \$148.10	
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) Fee: \$51.95 Benefit: 75% = \$39.00 85% = \$44.20	
30265 G 30266 S	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) Fee: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30 Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50	
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50	
30272	TONGUE, partial excision of (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95 85% = \$222.10	
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commandotype operation) (Anaes.) (Assist.) Fee: \$1,557.70 Benefit: 75% = \$1,168.30	
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes.) Fee: \$41.10 Benefit: 75% = \$30.85 85% = \$34.95	
30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.) Fee: \$105.55 Benefit: 75% = \$79.20 85% = \$89.75	
30282 G 30283 S	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) Fee: \$137.30 Benefit: 75% = \$103.00 85% = \$116.75 Fee: \$180.85 Benefit: 75% = \$135.65 85% = \$153.75	
30286	BRANCHIAL CYST, removal of (Anaes.) (Assist.) Fee: \$351.60 Benefit: 75% = \$263.70 85% = \$298.90	

OPERATIONS	GENERAL
30289	BRANCHIAL FISTULA, removal of (Anaes.) (Assist.) Fee: \$443.85 Benefit: 75% = \$332.90
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.) Fee: \$393.60 Benefit: 75% = \$295.20 85% = \$334.60
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) Fee: \$1,557.70 Benefit: 75% = \$1,168.30
30296	THYROIDECTOMY, total (Anaes.) (Assist.) Fee: \$904.60 Benefit: 75% = \$678.45
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) Fee: \$904.60 Benefit: 75% = \$678.45
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.) (Assist.) <i>(See para T8.16 of explanatory notes to this Category)</i> Fee: \$563.25 Benefit: 75% = \$422.45
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.) (Assist.) <i>(See para T8.16 of explanatory notes to this Category)</i> Fee: \$675.95 Benefit: 75% = \$507.00
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.) (Assist.) <i>(See para T8.16 of explanatory notes to this Category)</i> Fee: \$450.60 Benefit: 75% = \$337.95
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.) (Assist.) <i>(See para T8.16 of explanatory notes to this Category)</i> Fee: \$540.70 Benefit: 75% = \$405.55
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) Fee: \$705.70 Benefit: 75% = \$529.30
30308	BILATERAL SUBTOTAL THYROIDECTOMY (Anaes.) (Assist.) Fee: \$705.70 Benefit: 75% = \$529.30
30309	THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (Anaes.) (Assist.) Fee: \$904.60 Benefit: 75% = \$678.45
30310	THYROID, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Anaes.) (Assist.) Fee: \$404.15 Benefit: 75% = \$303.15
30313	THYROGLOSSAL CYST, removal of (Anaes.) (Assist.) Fee: \$241.20 Benefit: 75% = \$180.90 85% = \$205.05
30314	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) Fee: \$404.15 Benefit: 75% = \$303.15
30315	PARATHYROID operation for hyperparathyroidism (Anaes.) (Assist.) Fee: \$1,007.25 Benefit: 75% = \$755.45
30317	CERVICAL REEXPLORATION for recurrent or persistent hyperparathyroidism (Anaes.) (Assist.) Fee: \$1,206.10 Benefit: 75% = \$904.60
30318	MEDIASTINUM, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) Fee: \$802.00 Benefit: 75% = \$601.50

OPERATIONS	GENERAL
30320	MEDIASTINUM, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) Fee: \$1,206.10 Benefit: 75% = \$904.60
30321	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of (Anaes.) (Assist.) Fee: \$802.00 Benefit: 75% = \$601.50
30323	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of, requiring complex and extensive dissection (Anaes.) (Assist.) Fee: \$1,206.10 Benefit: 75% = \$904.60
30324	ADRENAL GLAND TUMOUR, excision of (Anaes.) (Assist.) Fee: \$1,206.10 Benefit: 75% = \$904.60
30329	LYMPH GLANDS of GROIN, limited excision of (Anaes.) Fee: \$218.20 Benefit: 75% = \$163.65 85% = \$185.50
30330	LYMPH GLANDS of GROIN, radical excision of (Anaes.) (Assist.) Fee: \$635.10 Benefit: 75% = \$476.35
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.) Fee: \$306.45 Benefit: 75% = \$229.85
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$766.00 Benefit: 75% = \$574.50
30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$919.25 Benefit: 75% = \$689.45
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) Fee: \$427.05 Benefit: 75% = \$320.30
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.) <i>(See para T8.18 of explanatory notes to this Category)</i> Fee: \$460.55 Benefit: 75% = \$345.45
30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45
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: \$462.70 Benefit: 75% = \$347.05
30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.) Fee: \$820.15 Benefit: 75% = \$615.15
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.) Fee: \$1,154.85 Benefit: 75% = \$866.15
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.) Fee: \$971.50 Benefit: 75% = \$728.65
30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.) Fee: \$497.75 Benefit: 75% = \$373.35
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: \$561.10 Benefit: 75% = \$420.85

OPERATIONS		GENERAL
30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.) Fee: \$1,411.60 Benefit: 75% = \$1,058.70	
30390	LAPAROSCOPY, diagnostic (Anaes.) Fee: \$194.35 Benefit: 75% = \$145.80	
30391	LAPAROSCOPY with biopsy (Anaes.) (Assist.) Fee: \$251.25 Benefit: 75% = \$188.45	
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) Fee: \$596.00 Benefit: 75% = \$447.00	
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: \$462.70 Benefit: 75% = \$347.05	
30394	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendectomy (Anaes.) (Assist.) Fee: \$435.45 Benefit: 75% = \$326.60	
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.) <i>(See para T8.19 of explanatory notes to this Category)</i> Fee: \$898.30 Benefit: 75% = \$673.75	
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: \$205.30 Benefit: 75% = \$154.00	
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: \$282.40 Benefit: 75% = \$211.80	
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) Fee: \$558.90 Benefit: 75% = \$419.20	
30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.) Fee: \$410.55 Benefit: 75% = \$307.95	
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45	
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: \$808.50 Benefit: 75% = \$606.40	
30406	PARACENTESIS ABDOMINIS (Anaes.) Fee: \$46.15 Benefit: 75% = \$34.65 85% = \$39.25	
30408	PERITONEO venous (Leveen) shunt, insertion of (Anaes.) (Assist.) Fee: \$346.50 Benefit: 75% = \$259.90	
30409	LIVER BIOPSY, percutaneous (Anaes.) Fee: \$154.20 Benefit: 75% = \$115.65 85% = \$131.10	
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) Fee: \$78.45 Benefit: 75% = \$58.85	
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) Fee: \$46.25 Benefit: 75% = \$34.70 85% = \$39.35	
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) Fee: \$609.55 Benefit: 75% = \$457.20	

OPERATIONS		GENERAL
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) Fee: \$1,219.05 Benefit: 75% = \$914.30	
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.) Fee: \$661.85 Benefit: 75% = \$496.40	
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.) Fee: \$992.70 Benefit: 75% = \$744.55	
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) Fee: \$1,411.60 Benefit: 75% = \$1,058.70	
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: \$722.05 Benefit: 75% = \$541.55 85% = \$658.15	
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.) (Assist.) Fee: \$1,764.30 Benefit: 75% = \$1,323.25	
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) Fee: \$596.70 Benefit: 75% = \$447.55	
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) Fee: \$1,154.85 Benefit: 75% = \$866.15	
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) Fee: \$1,379.35 Benefit: 75% = \$1,034.55	
30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.) Fee: \$1,475.65 Benefit: 75% = \$1,106.75 85% = \$1,411.75	
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.) Fee: \$2,053.05 Benefit: 75% = \$1,539.80 85% = \$1,989.15	
30431	LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45 85% = \$396.65	
30433	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.) Fee: \$641.55 Benefit: 75% = \$481.20	
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.) Fee: \$519.75 Benefit: 75% = \$389.85	
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: \$577.45 Benefit: 75% = \$433.10	
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.) Fee: \$718.65 Benefit: 75% = \$539.00	
30438	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.) Fee: \$1,016.95 Benefit: 75% = \$762.75 85% = \$953.05	
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: \$164.05 Benefit: 75% = \$123.05	
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: \$465.10 Benefit: 75% = \$348.85 85% = \$401.20	
30441	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.) Fee: \$120.40 Benefit: 75% = \$90.30	
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.) Fee: \$164.05 Benefit: 75% = \$123.05	

OPERATIONS		GENERAL
30443	CHOLECYSTECTOMY (Anaes.) (Assist.) Fee: \$653.30 Benefit: 75% = \$490.00	
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.) Fee: \$653.30 Benefit: 75% = \$490.00	
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.) Fee: \$653.30 Benefit: 75% = \$490.00	
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.) Fee: \$859.75 Benefit: 75% = \$644.85	
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.) Fee: \$956.00 Benefit: 75% = \$717.00	
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: \$463.35 Benefit: 75% = \$347.55 85% = \$399.45	
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: \$236.50 Benefit: 75% = \$177.40 85% = \$201.05	
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) Fee: \$333.60 Benefit: 75% = \$250.20	
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.) Fee: \$762.15 Benefit: 75% = \$571.65	
30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.) Fee: \$896.10 Benefit: 75% = \$672.10	
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.) Fee: \$1,219.05 Benefit: 75% = \$914.30 85% = \$1,155.15	
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: \$896.10 Benefit: 75% = \$672.10	
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) Fee: \$762.15 Benefit: 75% = \$571.65	
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: \$1,306.40 Benefit: 75% = \$979.80	
30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.) Fee: \$1,603.95 Benefit: 75% = \$1,203.00	
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: \$1,924.80 Benefit: 75% = \$1,443.60	
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) Fee: \$1,109.95 Benefit: 75% = \$832.50	
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) Fee: \$1,372.95 Benefit: 75% = \$1,029.75	
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) Fee: \$1,520.65 Benefit: 75% = \$1,140.50 85% = \$1,456.75	

OPERATIONS		GENERAL
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: \$821.20 Benefit: 75% = \$615.90 85% = \$757.30	
30473	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30476 or 30478 applies (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$156.50 Benefit: 75% = \$117.40 85% = \$133.05	
30475	ENDOSCOPY with balloon dilatation of gastric or gastroduodenal stricture (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$283.00 Benefit: 75% = \$212.25 85% = \$240.55	
30476	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with endoscopic sclerosing injection or banding of oesophageal or gastric varices, not being a service associated with a service to which item 30473 or 30478 applies (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$217.00 Benefit: 75% = \$162.75 85% = \$184.45	
30478	OESOPHAGOSCOPY (not being a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with 1 or more of the following endoscopic procedures - polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastrointestinal lesions, not being a service associated with a service to which item 30473 or 30476 applies (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$217.00 Benefit: 75% = \$162.75 85% = \$184.45	
30479	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions or strictures of the gastrointestinal tract (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$420.70 Benefit: 75% = \$315.55 85% = \$357.60	
30481	PERCUTANEOUS GASTROSTOMY (initial procedure), including any associated imaging services (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$315.50 Benefit: 75% = \$236.65 85% = \$268.20	
30482	PERCUTANEOUS GASTROSTOMY (repeat procedure), including any associated imaging services (Anaes.) Fee: \$224.30 Benefit: 75% = \$168.25 85% = \$190.70	
30483	GASTROSTOMY BUTTON, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes.) Fee: \$156.45 Benefit: 75% = \$117.35 85% = \$133.00	
30484	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$322.45 Benefit: 75% = \$241.85 85% = \$274.10	
30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$497.75 Benefit: 75% = \$373.35 85% = \$433.85	
30487	SMALL BOWEL INTUBATION with biopsy (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$159.85 Benefit: 75% = \$119.90 85% = \$135.90	
30488	SMALL BOWEL INTUBATION as an independent procedure (Anaes.) Fee: \$79.50 Benefit: 75% = \$59.65 85% = \$67.60	
30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$465.10 Benefit: 75% = \$348.85 85% = \$401.20	
30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$490.70 Benefit: 75% = \$368.05 85% = \$426.80	
30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$695.65 Benefit: 75% = \$521.75	

OPERATIONS		GENERAL
30493	BILIARY MANOMETRY (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30	
30494	ENDOSCOPIC BILIARY DILATATION (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$371.55 Benefit: 75% = \$278.70	
30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$695.65 Benefit: 75% = \$521.75	
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.) Fee: \$519.75 Benefit: 75% = \$389.85 85% = \$455.85	
30497	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.) Fee: \$619.65 Benefit: 75% = \$464.75	
30499	VAGOTOMY, highly selective (Anaes.) (Assist.) Fee: \$737.05 Benefit: 75% = \$552.80	
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.) Fee: \$789.15 Benefit: 75% = \$591.90 85% = \$725.25	
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.) Fee: \$871.05 Benefit: 75% = \$653.30	
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.) Fee: \$975.30 Benefit: 75% = \$731.50 85% = \$911.40	
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.) Fee: \$487.60 Benefit: 75% = \$365.70	
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.) Fee: \$853.40 Benefit: 75% = \$640.05	
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.) Fee: \$898.30 Benefit: 75% = \$673.75	
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.) Fee: \$898.30 Benefit: 75% = \$673.75 85% = \$834.40	
30511	<i>(see Item 31441 for repair, revision or replacement of implanted reservoir associated with adjustable gastric band)</i> <i>(see Item 14215 for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band)</i> MORBID OBESITY, gastric reduction or gastroplasty for, by any method (Anaes.) (Assist.) Fee: \$750.70 Benefit: 75% = \$563.05	
30512	MORBID OBESITY, gastric bypass for, by any method including anastomosis (Anaes.) (Assist.) Fee: \$923.80 Benefit: 75% = \$692.85	
30514	MORBID OBESITY, surgical reversal, by any method, of procedure to which item 30511 or 30512 applies (Anaes.) (Assist.) <i>(See para T8.21 of explanatory notes to this Category)</i> Fee: \$1,360.05 Benefit: 75% = \$1,020.05	
30515	GASTROENTEROSTOMY (INCLUDING GASTRODUODENOSTOMY) OR ENTEROCOLOSTOMY OR ENTEROENTEROSTOMY (Anaes.) (Assist.) Fee: \$622.35 Benefit: 75% = \$466.80	
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.) Fee: \$814.85 Benefit: 75% = \$611.15	
30518	PARTIAL GASTRECTOMY (Anaes.) (Assist.) Fee: \$872.60 Benefit: 75% = \$654.45	

OPERATIONS	GENERAL
30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.) Fee: \$596.70 Benefit: 75% = \$447.55
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) Fee: \$1,276.75 Benefit: 75% = \$957.60
30523	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.) <i>(See para T8.22 of explanatory notes to this Category)</i> Fee: \$1,334.40 Benefit: 75% = \$1,000.80
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.) Fee: \$1,469.15 Benefit: 75% = \$1,101.90
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: \$1,905.45 Benefit: 75% = \$1,429.10
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.) <i>(See para T8.23 of explanatory notes to this Category)</i> Fee: \$769.95 Benefit: 75% = \$577.50
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.) <i>(See para T8.23 of explanatory notes to this Category)</i> Fee: \$1,154.85 Benefit: 75% = \$866.15
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) <i>(See para T8.23 of explanatory notes to this Category)</i> Fee: \$692.95 Benefit: 75% = \$519.75
30532	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) <i>(See para T8.23 of explanatory notes to this Category)</i> Fee: \$795.65 Benefit: 75% = \$596.75
30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) <i>(See para T8.23 of explanatory notes to this Category)</i> Fee: \$946.45 Benefit: 75% = \$709.85
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.) Fee: \$1,499.20 Benefit: 75% = \$1,124.40
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.) Fee: \$1,520.65 Benefit: 75% = \$1,140.50
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: \$1,052.25 Benefit: 75% = \$789.20
30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) Fee: \$769.95 Benefit: 75% = \$577.50
30541	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.) Fee: \$1,340.95 Benefit: 75% = \$1,005.75
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: \$911.05 Benefit: 75% = \$683.30
30544	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.) Fee: \$667.25 Benefit: 75% = \$500.45

OPERATIONS		GENERAL
30545	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.) Fee: \$1,623.35 Benefit: 75% = \$1,217.55	
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,116.35 Benefit: 75% = \$837.30 85% = \$1,052.45	
30548	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) Fee: \$834.00 Benefit: 75% = \$625.50 85% = \$770.10	
30550	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.) (Assist.) Fee: \$1,822.20 Benefit: 75% = \$1,366.65	
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: \$1,257.55 Benefit: 75% = \$943.20	
30553	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) Fee: \$930.20 Benefit: 75% = \$697.65 85% = \$866.30	
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.) Fee: \$2,027.45 Benefit: 75% = \$1,520.60	
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,398.60 Benefit: 75% = \$1,048.95	
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.) Fee: \$1,032.95 Benefit: 75% = \$774.75	
30559	OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.) Fee: \$750.70 Benefit: 75% = \$563.05 85% = \$686.80	
30560	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.) Fee: \$834.00 Benefit: 75% = \$625.50	
30562	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel (Anaes.) (Assist.) Fee: \$525.80 Benefit: 75% = \$394.35	
30563	COLOSTOMY OR ILEOSTOMY, refashioning of (Anaes.) (Assist.) Fee: \$525.80 Benefit: 75% = \$394.35 85% = \$461.90	
30564	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.) Fee: \$682.45 Benefit: 75% = \$511.85	
30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) Fee: \$769.95 Benefit: 75% = \$577.50	
30566	SMALL INTESTINE, resection of, with anastomosis (Anaes.) (Assist.) Fee: \$855.30 Benefit: 75% = \$641.50	
30568	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.) (Assist.) Fee: \$641.55 Benefit: 75% = \$481.20	
30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.) (Assist.) Fee: \$327.15 Benefit: 75% = \$245.40	
30571	APPENDICECTOMY, not being a service to which item 30574 applies (Anaes.) (Assist.) Fee: \$393.60 Benefit: 75% = \$295.20	
30572	LAPAROSCOPIC APPENDICECTOMY (Anaes.) (Assist.) Fee: \$393.60 Benefit: 75% = \$295.20	

OPERATIONS		GENERAL
30605	PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes.) (Assist.) Fee: \$1,648.85 Benefit: 75% = \$1,236.65	
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) Fee: \$981.60 Benefit: 75% = \$736.20	
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: \$410.45 Benefit: 75% = \$307.85	
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: \$314.90 Benefit: 75% = \$236.20 Fee: \$410.45 Benefit: 75% = \$307.85	
30615	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45	
30616 G 30617 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person under 10 years of age (Anaes.) Fee: \$234.45 Benefit: 75% = \$175.85 Fee: \$314.90 Benefit: 75% = \$236.20	
30620 G 30621 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person 10 years of age or over (Anaes.) (Assist.) Fee: \$264.65 Benefit: 75% = \$198.50 Fee: \$360.10 Benefit: 75% = \$270.10	
30628	HYDROCELE, tapping of Fee: \$31.45 Benefit: 75% = \$23.60 85% = \$26.75	
30631	HYDROCELE, removal of, not being a service associated with a service to which items 30638, 30641 and 30644 apply (Anaes.) Fee: \$209.10 Benefit: 75% = \$156.85 85% = \$177.75	
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: \$207.70 Benefit: 75% = \$155.80 Fee: \$257.90 Benefit: 75% = \$193.45	
30638 G 30641 S	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.) Fee: \$264.65 Benefit: 75% = \$198.50 Fee: \$360.10 Benefit: 75% = \$270.10	
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: \$460.55 Benefit: 75% = \$345.45	
30653	CIRCUMCISION of a male UNDER 6 MONTHS of age (Anaes.) Fee: \$41.10 Benefit: 75% = \$30.85 85% = \$34.95	
30656	CIRCUMCISION of a male UNDER 10 YEARS of age but not less than 6 months of age (Anaes.) Fee: \$95.55 Benefit: 75% = \$71.70 85% = \$81.25	
30659 G 30660 S	CIRCUMCISION of a male 10 YEARS OF AGE OR OVER (Anaes.) Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50 Fee: \$164.05 Benefit: 75% = \$123.05 85% = \$139.45	
30663	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia (Anaes.) Fee: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45	
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: \$41.95 Benefit: 75% = \$31.50 85% = \$35.70	
30672	COCCYX, excision of (Anaes.) (Assist.) Fee: \$393.60 Benefit: 75% = \$295.20	

OPERATIONS		GENERAL
30675 G 30676 S	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.) Fee: \$264.65 Benefit: 75% = \$198.50 85% = \$225.00 Fee: \$335.00 Benefit: 75% = \$251.25 85% = \$284.75	
30679	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.) Fee: \$85.10 Benefit: 75% = \$63.85 85% = \$72.35	
31000	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 6 or fewer sections (Anaes.) Fee: \$513.25 Benefit: 75% = \$384.95 85% = \$449.35	
31001	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 7 to 12 sections (inclusive) (Anaes.) Fee: \$641.55 Benefit: 75% = \$481.20 85% = \$577.65	
31002	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 13 or more sections (Anaes.) Fee: \$769.95 Benefit: 75% = \$577.50 85% = \$706.05	
31200	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), removal by surgical excision (other than shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane , not being a service associated with a service to which item 45200, 45203 or 45206 applies and not being a service to which another item in this Group applies <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$30.05 Benefit: 75% = \$22.55 85% = \$25.55	
31205	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), lesion size up to 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, <i>where the specimen excised is sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$84.30 Benefit: 75% = \$63.25 85% = \$71.70	
31210	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), lesion size more than 10mm and up to 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, <i>where the specimen excised is sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$108.80 Benefit: 75% = \$81.60 85% = \$92.50	
31215	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), lesion size more than 20mm in diameter, removal by surgical excision (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, <i>where the specimen excised is sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$126.80 Benefit: 75% = \$95.10 85% = \$107.80	
31220	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), lesion size up to 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 - <i>where the specimens excised are sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$189.60 Benefit: 75% = \$142.20 85% = \$161.20	

OPERATIONS	GENERAL
31225	<p>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)</p> <p>Fee: \$336.95 Benefit: 75% = \$252.75 85% = \$286.45</p>
31230	<p>TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal by surgical excision (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)</p> <p>Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25</p>
31235	<p>TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal by surgical excision (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)</p> <p>Fee: \$126.80 Benefit: 75% = \$95.10 85% = \$107.80</p>
31240	<p>TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal by surgical excision (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)</p> <p>Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25</p>
31245	<p>SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HYDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.) (See para T8.24 and T8.25 of explanatory notes to this Category)</p> <p>Fee: \$326.05 Benefit: 75% = \$244.55 85% = \$277.15</p>
31250	<p>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)</p> <p>Fee: \$326.05 Benefit: 75% = \$244.55 85% = \$277.15</p>
31255	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to 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)</p> <p>Fee: \$195.60 Benefit: 75% = \$146.70 85% = \$166.30</p>
31256	<p>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)</p> <p>Fee: \$195.60 Benefit: 75% = \$146.70 85% = \$166.30</p>
31257	<p>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)</p> <p>Fee: \$195.60 Benefit: 75% = \$146.70 85% = \$166.30</p>

OPERATIONS	GENERAL
31258	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$195.60 Benefit: 75% = \$146.70 85% = \$166.30</p>
31260	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter - where removal is by 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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$278.95 Benefit: 75% = \$209.25 85% = \$237.15</p>
31261	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$278.95 Benefit: 75% = \$209.25 85% = \$237.15</p>
31262	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$278.95 Benefit: 75% = \$209.25 85% = \$237.15</p>
31263	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$278.95 Benefit: 75% = \$209.25 85% = \$237.15</p>
31265	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$163.00 Benefit: 75% = \$122.25 85% = \$138.55</p>
31266	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$163.00 Benefit: 75% = \$122.25 85% = \$138.55</p>
31267	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$163.00 Benefit: 75% = \$122.25 85% = \$138.55</p>

OPERATIONS	GENERAL
31268	<p>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, <u>where the tumour size is up to and including 10mm in diameter</u> 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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$163.00 Benefit: 75% = \$122.25 85% = \$138.55</p>
31270	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$228.25 Benefit: 75% = \$171.20 85% = \$194.05</p>
31271	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$228.25 Benefit: 75% = \$171.20 85% = \$194.05</p>
31272	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$228.25 Benefit: 75% = \$171.20 85% = \$194.05</p>
31273	<p>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, <u>where the tumour size is more than 10mm and up to and including 20mm in diameter</u> 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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$228.25 Benefit: 75% = \$171.20 85% = \$194.05</p>
31275	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$264.45 Benefit: 75% = \$198.35 85% = \$224.80</p>
31276	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$264.45 Benefit: 75% = \$198.35 85% = \$224.80</p>
31277	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$264.45 Benefit: 75% = \$198.35 85% = \$224.80</p>

OPERATIONS	GENERAL
31278	<p>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.) <i>(See para T8.24 and T8.25 of explanatory notes to this Category)</i> Fee: \$264.45 Benefit: 75% = \$198.35 85% = \$224.80</p>
31280	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from areas of the body not covered by items 31255 and 31265, tumour size up to 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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$137.70 Benefit: 75% = \$103.30 85% = \$117.05</p>
31281	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$138.25 Benefit: 75% = \$103.70 85% = \$117.55</p>
31282	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$138.25 Benefit: 75% = \$103.70 85% = \$117.55</p>
31283	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$138.25 Benefit: 75% = \$103.70 85% = \$117.55</p>
31285	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from areas of the body not covered by items 31260 and 31270, tumour size more than 10mm and up to 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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$188.20 Benefit: 75% = \$141.15 85% = \$160.00</p>
31286	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$188.20 Benefit: 75% = \$141.15 85% = \$160.00</p>
31287	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$188.20 Benefit: 75% = \$141.15 85% = \$160.00</p>

OPERATIONS		GENERAL
31288	<p>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)</p> <p>Fee: \$188.20 Benefit: 75% = \$141.15 85% = \$160.00</p>	
31290	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from areas of the body not covered by items 31260 and 31275, tumour size more than 20mm in diameter 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)</p> <p>Fee: \$217.25 Benefit: 75% = \$162.95 85% = \$184.70</p>	
31291	<p>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)</p> <p>Fee: \$217.25 Benefit: 75% = \$162.95 85% = \$184.70</p>	
31292	<p>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)</p> <p>Fee: \$217.25 Benefit: 75% = \$162.95 85% = \$184.70</p>	
31293	<p>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)</p> <p>Fee: \$217.25 Benefit: 75% = \$162.95 85% = \$184.70</p>	
31295	<p>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)</p> <p>Fee: \$258.75 Benefit: 75% = \$194.10 85% = \$219.95</p>	
TREATMENT OF MALIGNANT MELANOMA AND LOCALLY AGGRESSIVE SKIN TUMOURS		
<p>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".</p>		
31300	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to 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)</p> <p>Fee: \$282.70 Benefit: 75% = \$212.05 85% = \$240.30</p>	
31305	<p>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)</p> <p>Fee: \$347.75 Benefit: 75% = \$260.85 85% = \$295.60</p>	

OPERATIONS	GENERAL
31310	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) <u>tumour size up to and including 10mm in diameter</u> 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.) (See para T8.24 and T8.25 of explanatory notes to this Category) Fee: \$246.25 Benefit: 75% = \$184.70 85% = \$209.35</p>
31315	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) <u>tumour size more than 10mm and up to and including 20mm in diameter</u> 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.) (See para T8.24 and T8.25 of explanatory notes to this Category) Fee: \$311.50 Benefit: 75% = \$233.65 85% = \$264.80</p>
31320	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) <u>tumour size more than 20mm in diameter</u> 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.) (See para T8.24 and T8.25 of explanatory notes to this Category) Fee: \$347.75 Benefit: 75% = \$260.85 85% = \$295.60</p>
31325	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from areas of the body not covered by items 31300 and 31310 - <u>tumour size up to and including 10mm in diameter</u> 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: \$239.10 Benefit: 75% = \$179.35 85% = \$203.25</p>
31330	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from areas of the body not covered by items 31305 and 31310 - <u>tumour size more than 10mm and up to and including 20mm in diameter</u> 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: \$282.70 Benefit: 75% = \$212.05 85% = \$240.30</p>
31335	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from areas of the body not covered by items 31305 and 31320 - <u>tumour size more than 20mm in diameter</u> 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: \$326.05 Benefit: 75% = \$244.55 85% = \$277.15</p>
31340	<p>NOTE: Multiple Operation and Multiple Anaesthetic rules apply to this item. MUSCLE, BONE OR CARTILAGE, excision of one or more of, where clinically indicated, 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.) (See para T8.24 of explanatory notes to this Category) Derived Fee: 75% of the fee for excision of malignant tumour</p>
31345	<p>LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and <u>50mm or more in diameter</u>, or is sub-fascial, where the specimen is sent for histological confirmation of diagnosis (Anaes.) (See para T8.24 of explanatory notes to this Category) Fee: \$186.35 Benefit: 75% = \$139.80 85% = \$158.40</p>
31346	<p>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.) Fee: \$186.35 Benefit: 75% = \$139.80 85% = \$158.40</p>

OPERATIONS	GENERAL
31350	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$382.95 Benefit: 75% = \$287.25 85% = \$325.55</p>
31355	<p>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.) <i>(See para T8.24 of explanatory notes to this Category)</i> Fee: \$631.30 Benefit: 75% = \$473.50 85% = \$567.40</p>
31400	<p>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: \$230.70 Benefit: 75% = \$173.05 85% = \$196.10</p>
31403	<p>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: \$266.25 Benefit: 75% = \$199.70</p>
31406	<p>MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) Fee: \$443.75 Benefit: 75% = \$332.85 85% = \$379.85</p>
31409	<p>PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) Fee: \$1,378.60 Benefit: 75% = \$1,033.95</p>
31412	<p>RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) Fee: \$1,698.10 Benefit: 75% = \$1,273.60</p>
31420	<p>LYMPH NODE OF NECK, biopsy of (Anaes.) Fee: \$162.50 Benefit: 75% = \$121.90 85% = \$138.15</p>
31423	<p>LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.) <i>(See para T8.26 of explanatory notes to this Category)</i> Fee: \$354.95 Benefit: 75% = \$266.25 85% = \$301.75</p>
31426	<p>LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.) <i>(See para T8.26 of explanatory notes to this Category)</i> Fee: \$710.00 Benefit: 75% = \$532.50</p>
31429	<p>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.) <i>(See para T8.26 of explanatory notes to this Category)</i> Fee: \$1,106.40 Benefit: 75% = \$829.80</p>
31432	<p>LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.) <i>(See para T8.26 of explanatory notes to this Category)</i> Fee: \$1,183.35 Benefit: 75% = \$887.55</p>
31435	<p>LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.) <i>(See para T8.26 of explanatory notes to this Category)</i> Fee: \$869.75 Benefit: 75% = \$652.35</p>
31438	<p>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.) <i>(See para T8.26 of explanatory notes to this Category)</i> Fee: \$1,378.60 Benefit: 75% = \$1,033.95</p>
31441	<p><i>(see Item 14215 for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band)</i> LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, repair, revision or replacement of (Anaes.) Fee: \$222.35 Benefit: 75% = \$166.80 85% = \$189.00</p>

OPERATIONS	GENERAL
31450	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.) Fee: \$359.35 Benefit: 75% = \$269.55
31452	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.) Fee: \$628.70 Benefit: 75% = \$471.55
31454	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.) Fee: \$497.75 Benefit: 75% = \$373.35
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: \$217.00 Benefit: 75% = \$162.75
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: \$260.40 Benefit: 75% = \$195.30
31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) Fee: \$315.50 Benefit: 75% = \$236.65
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45
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.) <i>(See para T8.23 of explanatory notes to this Category)</i> Fee: \$769.95 Benefit: 75% = \$577.50
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.) <i>(See para T8.23 of explanatory notes to this Category)</i> Fee: \$1,154.90 Benefit: 75% = \$866.20
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: \$1,268.80 Benefit: 75% = \$951.60
31470	LAPAROSCOPIC SPLENECTOMY (Anaes.) (Assist.) Fee: \$636.40 Benefit: 75% = \$477.30
31472	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.) Fee: \$1,033.70 Benefit: 75% = \$775.30
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.) <i>(See para T8.27 of explanatory notes to this Category)</i> Fee: \$229.80 Benefit: 75% = \$172.35 85% = \$195.35
31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.) <i>(See para T8.27 of explanatory notes to this Category)</i> Fee: \$306.45 Benefit: 75% = \$229.85 85% = \$260.50
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.) <i>(See para T8.27 of explanatory notes to this Category)</i> Fee: \$344.70 Benefit: 75% = \$258.55
31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.) <i>(See para T8.27 of explanatory notes to this Category)</i> Fee: \$306.45 Benefit: 75% = \$229.85 85% = \$260.50

OPERATIONS		GENERAL	
31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.) <i>(See para T8.27 of explanatory notes to this Category)</i> Fee: \$574.55 Benefit: 75% = \$430.95		
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.) <i>(See para T8.27 of explanatory notes to this Category)</i> Fee: \$385.40 Benefit: 75% = \$289.05		
31518	BREAST (female), total mastectomy (Anaes.) (Assist.) Fee: \$650.60 Benefit: 75% = \$487.95		
31521	BREAST (male), total mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.) <i>(See para T8.28 of explanatory notes to this Category)</i> Fee: \$383.05 Benefit: 75% = \$287.30 85% = \$325.60		
31524	BREAST (female), subcutaneous mastectomy (Anaes.) (Assist.) <i>(See para T8.28 of explanatory notes to this Category)</i> Fee: \$919.25 Benefit: 75% = \$689.45		
31527	BREAST (male), subcutaneous mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.) <i>(See para T8.28 of explanatory notes to this Category)</i> Fee: \$459.70 Benefit: 75% = \$344.80 85% = \$395.80		
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: \$526.35 Benefit: 75% = \$394.80 85% = \$462.45		
31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) <i>(See para T8.29 of explanatory notes to this Category)</i> Fee: \$121.85 Benefit: 75% = \$91.40 85% = \$103.60		
31536	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.) Fee: \$167.35 Benefit: 75% = \$125.55 85% = \$142.25		
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.) <i>(See para T8.30 of explanatory notes to this Category)</i> Fee: \$352.40 Benefit: 75% = \$264.30		
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.) <i>(See para T8.31 of explanatory notes to this Category)</i> Fee: \$174.00 Benefit: 75% = \$130.50 85% = \$147.90		
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.) <i>(See para T8.30 of explanatory notes to this Category)</i> Fee: \$526.35 Benefit: 75% = \$394.80 85% = \$462.45		
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: \$121.85 Benefit: 75% = \$91.40 85% = \$103.60		

OPERATIONS		COLORECTAL
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: \$191.55 Benefit: 75% = \$143.70 85% = \$162.85	
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.) Fee: \$383.05 Benefit: 75% = \$287.30	
31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.) Fee: \$306.45 Benefit: 75% = \$229.85 85% = \$260.50	
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) Fee: \$306.45 Benefit: 75% = \$229.85 85% = \$260.50	
31563	INVERTED NIPPLE, surgical eversion of (Anaes.) Fee: \$229.55 Benefit: 75% = \$172.20 85% = \$195.15	
31566	ACCESSORY NIPPLE, excision of (Anaes.) Fee: \$114.85 Benefit: 75% = \$86.15 85% = \$97.65	
SUBGROUP 2 - COLORECTAL		
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) Fee: \$911.35 Benefit: 75% = \$683.55	
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) Fee: \$953.35 Benefit: 75% = \$715.05	
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: \$1,016.50 Benefit: 75% = \$762.40	
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: \$1,148.35 Benefit: 75% = \$861.30	
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.) Fee: \$1,016.50 Benefit: 75% = \$762.40	
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) Fee: \$1,205.80 Benefit: 75% = \$904.35	
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) Fee: \$1,332.00 Benefit: 75% = \$999.00	
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) Fee: \$1,636.95 Benefit: 75% = \$1,227.75	
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) Fee: \$1,388.00 Benefit: 75% = \$1,041.00	
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) Fee: \$497.75 Benefit: 75% = \$373.35	
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: \$1,205.80 Benefit: 75% = \$904.35	

OPERATIONS	COLORECTAL
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: \$1,612.90 Benefit: 75% = \$1,209.70
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: \$1,736.95 Benefit: 75% = \$1,302.75
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.) Fee: \$1,861.10 Benefit: 75% = \$1,395.85
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.) Fee: \$372.20 Benefit: 75% = \$279.15
32030	RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes.) (Assist.) Fee: \$911.35 Benefit: 75% = \$683.55
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.) Fee: \$1,332.00 Benefit: 75% = \$999.00
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) Fee: \$1,689.40 Benefit: 75% = \$1,267.05
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) Fee: \$1,356.45 Benefit: 75% = \$1,017.35
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) Fee: \$1,142.65 Benefit: 75% = \$857.00
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) Fee: \$427.65 Benefit: 75% = \$320.75
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: \$660.85 Benefit: 75% = \$495.65
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) Fee: \$769.95 Benefit: 75% = \$577.50
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: \$2,047.05 Benefit: 75% = \$1,535.30
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: \$1,878.80 Benefit: 75% = \$1,409.10
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) Fee: \$497.75 Benefit: 75% = \$373.35
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: \$2,047.05 Benefit: 75% = \$1,535.30
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: \$1,878.80 Benefit: 75% = \$1,409.10

OPERATIONS	COLORECTAL
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: \$497.75 Benefit: 75% = \$373.35
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) Fee: \$1,514.30 Benefit: 75% = \$1,135.75
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy Fee: \$42.30 Benefit: 75% = \$31.75 85% = \$36.00
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: \$66.30 Benefit: 75% = \$49.75 85% = \$56.40
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: \$148.90 Benefit: 75% = \$111.70 85% = \$126.60
32081	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes.) Fee: \$204.55 Benefit: 75% = \$153.45 85% = \$173.90
32084	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure, WITH or WITHOUT BIOPSY (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$98.40 Benefit: 75% = \$73.80 85% = \$83.65
32087	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS not being a service to which item 32078 applies (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$180.85 Benefit: 75% = \$135.65 85% = \$153.75
32090	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH or WITHOUT BIOPSY (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$295.40 Benefit: 75% = \$221.55 85% = \$251.10
32093	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$414.60 Benefit: 75% = \$310.95 85% = \$352.45
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$487.60 Benefit: 75% = \$365.70
32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$112.95 Benefit: 75% = \$84.75 85% = \$96.05
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: \$227.05 Benefit: 75% = \$170.30 85% = \$193.00
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.) Fee: \$294.45 Benefit: 75% = \$220.85
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.) Fee: \$560.80 Benefit: 75% = \$420.60
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.) <i>(See para T8.20 and T8.32 of explanatory notes to this Category)</i> Fee: \$682.45 Benefit: 75% = \$511.85

OPERATIONS	COLORECTAL
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.) <i>(See para T8.20 and T8.32 of explanatory notes to this Category)</i> Fee: \$883.30 Benefit: 75% = \$662.50
32105	ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.) Fee: \$427.65 Benefit: 75% = \$320.75 85% = \$363.75
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.) <i>(See para T8.20 and T8.32 of explanatory notes to this Category)</i> Fee: \$1,205.80 Benefit: 75% = \$904.35 85% = \$1,141.90
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) Fee: \$883.30 Benefit: 75% = \$662.50
32111	RECTAL PROLAPSE Delorme procedure for (Anaes.) (Assist.) Fee: \$560.80 Benefit: 75% = \$420.60
32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.) Fee: \$682.45 Benefit: 75% = \$511.85
32114	RECTAL STRICTURE, per anal release of (Anaes.) Fee: \$154.20 Benefit: 75% = \$115.65 85% = \$131.10
32115	RECTAL STRICTURE, dilatation of (Anaes.) Fee: \$112.10 Benefit: 75% = \$84.10
32117	RECTAL PROLAPSE, abdominal rectopexy of (Anaes.) (Assist.) Fee: \$883.30 Benefit: 75% = \$662.50
32120	RECTAL PROLAPSE, perineal repair of (Anaes.) (Assist.) Fee: \$227.05 Benefit: 75% = \$170.30
32123	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.) Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.) Fee: \$427.65 Benefit: 75% = \$320.75
32129	ANAL SPHINCTER, direct repair of (Anaes.) (Assist.) Fee: \$560.80 Benefit: 75% = \$420.60
32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) Fee: \$471.50 Benefit: 75% = \$353.65
32132	HAEMORRHOIDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.) Fee: \$39.85 Benefit: 75% = \$29.90 85% = \$33.90
32135	HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.) Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75
32138	HAEMORRHOIDECTOMY including excision of anal skin tags when performed (Anaes.) Fee: \$324.95 Benefit: 75% = \$243.75 85% = \$276.25
32139	HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.) (Assist.) Fee: \$324.95 Benefit: 75% = \$243.75
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (Anaes.) Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75

OPERATIONS		COLORECTAL
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: \$119.35 Benefit: 75% = \$89.55 85% = \$101.45	
32147	PERIANAL THROMBOSIS, incision of (Anaes.) Fee: \$39.85 Benefit: 75% = \$29.90 85% = \$33.90	
32150	OPERATION FOR FISSURE IN ANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.) Fee: \$227.05 Benefit: 75% = \$170.30 85% = \$193.00	
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: \$61.95 Benefit: 75% = \$46.50	
32156	FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes.) Fee: \$116.40 Benefit: 75% = \$87.30 85% = \$98.95	
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: \$294.45 Benefit: 75% = \$220.85	
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: \$427.65 Benefit: 75% = \$320.75	
32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.) Fee: \$560.80 Benefit: 75% = \$420.60 85% = \$496.90	
32166	ANAL FISTULA - readjustment of Seton (Anaes.) Fee: \$182.20 Benefit: 75% = \$136.65 85% = \$154.90	
32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes.) Fee: \$116.40 Benefit: 75% = \$87.30	
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: \$78.45 Benefit: 75% = \$58.85	
32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) Fee: \$78.45 Benefit: 75% = \$58.85 85% = \$66.70	
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: \$143.70 Benefit: 75% = \$107.80	
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: \$154.00 Benefit: 75% = \$115.50	
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: \$227.05 Benefit: 75% = \$170.30	
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) Fee: \$496.35 Benefit: 75% = \$372.30	
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) Fee: \$496.35 Benefit: 75% = \$372.30	
32200	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95 85% = \$222.10	
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.) Fee: \$561.10 Benefit: 75% = \$420.85	

OPERATIONS	VASCULAR
32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.) Fee: \$506.95 Benefit: 75% = \$380.25
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.) Fee: \$814.65 Benefit: 75% = \$611.00
32210	GRACILIS NEOSPINCTER PACEMAKER, replacement of (Anaes.) Fee: \$225.75 Benefit: 75% = \$169.35 85% = \$191.90
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: \$120.40 Benefit: 75% = \$90.30 85% = \$102.35
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.) <i>(See para T8.33 of explanatory notes to this Category)</i> Fee: \$584.05 Benefit: 75% = \$438.05
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.) <i>(See para T8.33 of explanatory notes to this Category)</i> Fee: \$295.05 Benefit: 75% = \$221.30
32215	SACRAL NERVE ELECTRODE(S), management, adjustment, and electronic programming of neurostimulator by a medical practitioner, for the management of faecal incontinence - each day <i>(See para T8.33 of explanatory notes to this Category)</i> Fee: \$110.80 Benefit: 75% = \$83.10 85% = \$94.20
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.) <i>(See para T8.33 of explanatory notes to this Category)</i> Fee: \$524.50 Benefit: 75% = \$393.40
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.) <i>(See para T8.33 of explanatory notes to this Category)</i> Fee: \$138.15 Benefit: 75% = \$103.65
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.) <i>(See para T8.33 of explanatory notes to this Category)</i> Fee: \$138.15 Benefit: 75% = \$103.65
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.) <i>(See para T8.34 of explanatory notes to this Category)</i> Fee: \$97.00 Benefit: 75% = \$72.75 85% = \$82.45
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 <i>(See para T8.34 of explanatory notes to this Category)</i> Fee: \$97.00 Benefit: 75% = \$72.75 85% = \$82.45

OPERATIONS	VASCULAR
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: \$236.50 Benefit: 75% = \$177.40 85% = \$201.05
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: \$471.50 Benefit: 75% = \$353.65 85% = \$407.60
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: \$471.50 Benefit: 75% = \$353.65
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: \$701.00 Benefit: 75% = \$525.75
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: \$818.95 Benefit: 75% = \$614.25
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: \$1,054.55 Benefit: 75% = \$790.95
BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE	
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) Fee: \$1,269.15 Benefit: 75% = \$951.90
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.) Fee: \$1,049.95 Benefit: 75% = \$787.50
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) Fee: \$1,255.95 Benefit: 75% = \$942.00
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) Fee: \$1,395.55 Benefit: 75% = \$1,046.70
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: \$1,535.10 Benefit: 75% = \$1,151.35
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) Fee: \$1,109.70 Benefit: 75% = \$832.30
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) Fee: \$1,109.70 Benefit: 75% = \$832.30
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) Fee: \$1,049.95 Benefit: 75% = \$787.50
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) Fee: \$1,667.75 Benefit: 75% = \$1,250.85
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) Fee: \$1,893.75 Benefit: 75% = \$1,420.35
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) Fee: \$1,435.25 Benefit: 75% = \$1,076.45
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) Fee: \$1,667.75 Benefit: 75% = \$1,250.85

OPERATIONS	VASCULAR
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) Fee: \$365.40 Benefit: 75% = \$274.05
32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.) Fee: \$1,142.90 Benefit: 75% = \$857.20
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: \$1,309.15 Benefit: 75% = \$981.90
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: \$1,495.05 Benefit: 75% = \$1,121.30
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: \$1,621.35 Benefit: 75% = \$1,216.05
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) Fee: \$1,049.95 Benefit: 75% = \$787.50
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: \$1,309.15 Benefit: 75% = \$981.90
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: \$365.40 Benefit: 75% = \$274.05
32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10
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: \$1,049.95 Benefit: 75% = \$787.50
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: \$697.75 Benefit: 75% = \$523.35
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: \$241.85 Benefit: 75% = \$181.40
	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: \$1,285.95 Benefit: 75% = \$964.50
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) Fee: \$1,031.25 Benefit: 75% = \$773.45
33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$744.05 Benefit: 75% = \$558.05 85% = \$680.15
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$946.50 Benefit: 75% = \$709.90
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,155.30 Benefit: 75% = \$866.50

OPERATIONS		VASCULAR
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.) Fee: \$1,269.15 Benefit: 75% = \$951.90 85% = \$1,205.25	
33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$1,780.75 Benefit: 75% = \$1,335.60	
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) Fee: \$2,153.00 Benefit: 75% = \$1,614.75 85% = \$2,089.10	
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) Fee: \$1,867.20 Benefit: 75% = \$1,400.40	
33115	INFARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) Fee: \$1,255.95 Benefit: 75% = \$942.00	
+ 33116	INFARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Ministerial Determination) (Anaes.) (Assist.) <i>(See para T8.35 of explanatory notes to this Category)</i> Fee: \$1,236.20 Benefit: 75% = \$927.15 85% = \$1,172.30	
33118	INFARENAL 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: \$1,395.55 Benefit: 75% = \$1,046.70	
+ 33119	INFARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Ministerial Determination) (Anaes.) (Assist.) <i>(See para T8.35 of explanatory notes to this Category)</i> Fee: \$1,373.65 Benefit: 75% = \$1,030.25 85% = \$1,309.75	
33121	INFARENAL 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: \$1,535.10 Benefit: 75% = \$1,151.35	
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.) Fee: \$1,069.85 Benefit: 75% = \$802.40	
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.) Fee: \$1,402.10 Benefit: 75% = \$1,051.60 85% = \$1,338.20	
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) Fee: \$1,222.65 Benefit: 75% = \$917.00	
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) Fee: \$916.95 Benefit: 75% = \$687.75	
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) Fee: \$2,312.30 Benefit: 75% = \$1,734.25	
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) Fee: \$1,402.10 Benefit: 75% = \$1,051.60	
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.) Fee: \$1,309.15 Benefit: 75% = \$981.90 85% = \$1,245.25	
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$2,252.60 Benefit: 75% = \$1,689.45	
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$2,797.45 Benefit: 75% = \$2,098.10	
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$2,657.90 Benefit: 75% = \$1,993.45	

OPERATIONS	VASCULAR
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) Fee: \$1,966.90 Benefit: 75% = \$1,475.20
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: \$2,192.75 Benefit: 75% = \$1,644.60
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) Fee: \$2,192.75 Benefit: 75% = \$1,644.60
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$1,860.70 Benefit: 75% = \$1,395.55
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) Fee: \$1,860.70 Benefit: 75% = \$1,395.55 85% = \$1,796.80
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) Fee: \$1,448.60 Benefit: 75% = \$1,086.45
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) Fee: \$1,129.60 Benefit: 75% = \$847.20
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,041.05 Benefit: 75% = \$780.80
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,323.85 Benefit: 75% = \$992.90
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,618.60 Benefit: 75% = \$1,213.95
33500	<p style="text-align: center;">ENDARTERECTOMY AND ARTERIAL PATCH</p> 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: \$1,003.30 Benefit: 75% = \$752.50
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) Fee: \$1,123.05 Benefit: 75% = \$842.30
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) Fee: \$1,255.95 Benefit: 75% = \$942.00
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: \$1,395.55 Benefit: 75% = \$1,046.70
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: \$1,535.10 Benefit: 75% = \$1,151.35
33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.) Fee: \$1,123.05 Benefit: 75% = \$842.30 85% = \$1,059.15
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) Fee: \$1,215.95 Benefit: 75% = \$912.00
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) Fee: \$1,435.25 Benefit: 75% = \$1,076.45

OPERATIONS		VASCULAR
33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) Fee: \$1,667.75 Benefit: 75% = \$1,250.85	
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) Fee: \$1,435.25 Benefit: 75% = \$1,076.45	
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) Fee: \$1,667.75 Benefit: 75% = \$1,250.85	
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: \$1,189.50 Benefit: 75% = \$892.15	
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) Fee: \$857.20 Benefit: 75% = \$642.90	
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.) Fee: \$1,222.65 Benefit: 75% = \$917.00	
33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.) <i>(See para T8.38 of explanatory notes to this Category)</i> Fee: \$241.85 Benefit: 75% = \$181.40	
33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) <i>(See para T8.38 of explanatory notes to this Category)</i> Fee: \$491.85 Benefit: 75% = \$368.90	
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.) <i>(See para T8.38 of explanatory notes to this Category)</i> Fee: \$241.85 Benefit: 75% = \$181.40	
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.) Fee: \$240.65 Benefit: 75% = \$180.50	
EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA		
33800	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.) Fee: \$1,043.25 Benefit: 75% = \$782.45 85% = \$979.35	
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) Fee: \$996.75 Benefit: 75% = \$747.60	
33806	EMBOLECTOMY OR THROMBECTOMY, including the infusion of thrombolytic or other agents, from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery (Anaes.) (Assist.) <i>(See para T8.39 of explanatory notes to this Category)</i> Fee: \$717.65 Benefit: 75% = \$538.25 85% = \$653.75	
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.) Fee: \$523.50 Benefit: 75% = \$392.65 85% = \$459.60	
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) Fee: \$1,558.50 Benefit: 75% = \$1,168.90	
33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.) Fee: \$823.95 Benefit: 75% = \$618.00 85% = \$760.05	
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) Fee: \$757.55 Benefit: 75% = \$568.20	
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) Fee: \$883.80 Benefit: 75% = \$662.85	

OPERATIONS	VASCULAR
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: \$1,010.00 Benefit: 75% = \$757.50
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) Fee: \$963.45 Benefit: 75% = \$722.60
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) Fee: \$1,129.60 Benefit: 75% = \$847.20
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: \$1,295.70 Benefit: 75% = \$971.80
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) Fee: \$1,176.25 Benefit: 75% = \$882.20
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.) Fee: \$1,402.10 Benefit: 75% = \$1,051.60
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) Fee: \$1,641.25 Benefit: 75% = \$1,230.95
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) Fee: \$810.65 Benefit: 75% = \$608.00
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) Fee: \$564.80 Benefit: 75% = \$423.60
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) Fee: \$564.80 Benefit: 75% = \$423.60
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: \$624.70 Benefit: 75% = \$468.55
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: \$365.40 Benefit: 75% = \$274.05
34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.) Fee: \$257.80 Benefit: 75% = \$193.35 85% = \$219.15
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) Fee: \$298.95 Benefit: 75% = \$224.25 85% = \$254.15
34112	ARTERIO-VEIN FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) Fee: \$757.55 Benefit: 75% = \$568.20
34115	ARTERIO-VEIN FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) Fee: \$857.20 Benefit: 75% = \$642.90
34118	ARTERIO-VEIN FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) Fee: \$1,222.65 Benefit: 75% = \$917.00 85% = \$1,158.75

OPERATIONS	VASCULAR
34121	ARTERIO-VEINUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) Fee: \$976.75 Benefit: 75% = \$732.60
34124	ARTERIO-VEINUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) Fee: \$1,069.85 Benefit: 75% = \$802.40
34127	ARTERIO-VEINUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) Fee: \$1,402.10 Benefit: 75% = \$1,051.60
34130	SURGICALLY CREATED ARTERIO-VEINUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) Fee: \$438.55 Benefit: 75% = \$328.95 85% = \$374.65
34133	SCALENOTOMY (Anaes.) (Assist.) Fee: \$491.85 Benefit: 75% = \$368.90
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) Fee: \$790.65 Benefit: 75% = \$593.00
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: \$790.65 Benefit: 75% = \$593.00
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) Fee: \$976.75 Benefit: 75% = \$732.60
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) Fee: \$711.00 Benefit: 75% = \$533.25
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: \$1,269.15 Benefit: 75% = \$951.90
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: \$1,734.30 Benefit: 75% = \$1,300.75
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) Fee: \$2,066.60 Benefit: 75% = \$1,549.95 85% = \$2,002.70
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) Fee: \$1,049.95 Benefit: 75% = \$787.50
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) Fee: \$1,966.90 Benefit: 75% = \$1,475.20
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) Fee: \$2,525.05 Benefit: 75% = \$1,893.80
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) Fee: \$2,525.05 Benefit: 75% = \$1,893.80
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) Fee: \$1,402.10 Benefit: 75% = \$1,051.60
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) Fee: \$1,142.90 Benefit: 75% = \$857.20
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) Fee: \$1,049.95 Benefit: 75% = \$787.50

OPERATIONS		VASCULAR
OPERATIONS FOR VASCULAR ACCESS		
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.) Fee: \$272.50 Benefit: 75% = \$204.40 85% = \$231.65	
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) Fee: \$365.40 Benefit: 75% = \$274.05	
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) Fee: \$186.00 Benefit: 75% = \$139.50	
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.) Fee: \$863.80 Benefit: 75% = \$647.85	
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) Fee: \$950.25 Benefit: 75% = \$712.70	
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) Fee: \$677.75 Benefit: 75% = \$508.35	
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) Fee: \$1,136.20 Benefit: 75% = \$852.15	
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) Fee: \$698.00 Benefit: 75% = \$523.50	
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) Fee: \$365.40 Benefit: 75% = \$274.05	
34527	CENTRAL VEIN CATHETERISATION by <u>open technique</u> , using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation (Anaes.) Fee: \$487.45 Benefit: 75% = \$365.60 85% = \$423.55	
34528	CENTRAL VEIN CATHETERISATION by <u>percutaneous technique</u> , using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device (Anaes.) Fee: \$240.65 Benefit: 75% = \$180.50 85% = \$204.60	
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: \$180.50 Benefit: 75% = \$135.40 85% = \$153.45	
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: \$1,096.35 Benefit: 75% = \$822.30 85% = \$1,032.45	
34538	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.) Fee: \$240.65 Benefit: 75% = \$180.50 85% = \$204.60	
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: \$180.50 Benefit: 75% = \$135.40 85% = \$153.45	
COMPLEX VENOUS OPERATIONS		
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) Fee: \$717.65 Benefit: 75% = \$538.25 85% = \$653.75	

OPERATIONS		VASCULAR
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) Fee: \$1,581.55 Benefit: 75% = \$1,186.20	
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) Fee: \$857.20 Benefit: 75% = \$642.90	
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) Fee: \$857.20 Benefit: 75% = \$642.90	
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: \$1,036.60 Benefit: 75% = \$777.45	
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.) <i>(See para T8.38 of explanatory notes to this Category)</i> Fee: \$857.20 Benefit: 75% = \$642.90	
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) Fee: \$943.55 Benefit: 75% = \$707.70	
34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) Fee: \$1,282.55 Benefit: 75% = \$961.95 85% = \$1,218.65	
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) Fee: \$438.55 Benefit: 75% = \$328.95	
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) Fee: \$531.60 Benefit: 75% = \$398.70	
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) Fee: \$624.70 Benefit: 75% = \$468.55 85% = \$560.80	
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) Fee: \$810.65 Benefit: 75% = \$608.00	
SYMPATHECTOMY		
35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) Fee: \$624.70 Benefit: 75% = \$468.55 85% = \$560.80	
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) Fee: \$810.65 Benefit: 75% = \$608.00	
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) Fee: \$1,016.70 Benefit: 75% = \$762.55	
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) Fee: \$790.65 Benefit: 75% = \$593.00	
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) Fee: \$624.70 Benefit: 75% = \$468.55	
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: \$325.70 Benefit: 75% = \$244.30	
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) Fee: \$207.30 Benefit: 75% = \$155.50 85% = \$176.25	

OPERATIONS		VASCULAR
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: \$151.55 Benefit: 75% = \$113.70	
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: \$722.05 Benefit: 75% = \$541.55	
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: \$455.45 Benefit: 75% = \$341.60 85% = \$391.55	
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: \$583.90 Benefit: 75% = \$437.95 85% = \$520.00	
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: \$538.95 Benefit: 75% = \$404.25 85% = \$475.05	
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.) <i>(See para T8.40 of explanatory notes to this Category)</i> Fee: \$990.75 Benefit: 75% = \$743.10	
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: \$673.70 Benefit: 75% = \$505.30 85% = \$609.80	
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: \$763.50 Benefit: 75% = \$572.65	
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: \$763.50 Benefit: 75% = \$572.65	
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.) <i>(See para T8.41 of explanatory notes to this Category)</i> Fee: \$314.40 Benefit: 75% = \$235.80 85% = \$267.25	
35319	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) Fee: \$563.60 Benefit: 75% = \$422.70 85% = \$499.70	
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: \$757.05 Benefit: 75% = \$567.80 85% = \$693.15	

OPERATIONS	VASCULAR
35321	<p>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 T8.42 of explanatory notes to this Category)</p> <p>Fee: \$718.65 Benefit: 75% = \$539.00 85% = \$654.75</p>
35324	<p>ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p>Fee: \$269.40 Benefit: 75% = \$202.05</p>
35327	<p>ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p>Fee: \$361.15 Benefit: 75% = \$270.90</p>
35330	<p>INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p>Fee: \$455.45 Benefit: 75% = \$341.60 85% = \$391.55</p>
35331	<p>RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.)</p> <p>Fee: \$523.50 Benefit: 75% = \$392.65</p>
35360	<p>Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare</p> <p><i>(foreign body does not include an instrument inserted for the purpose of a service being rendered)</i> (Anaes.) (Assist.)</p> <p>Fee: \$731.80 Benefit: 75% = \$548.85</p>
35361	<p>Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare</p> <p><i>(foreign body does not include an instrument inserted for the purpose of a service being rendered)</i> (Anaes.) (Assist.)</p> <p>Fee: \$627.65 Benefit: 75% = \$470.75</p>
35362	<p>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</p> <p><i>(foreign body does not include an instrument inserted for the purpose of a service being rendered)</i> (Anaes.) (Assist.)</p> <p>Fee: \$523.50 Benefit: 75% = \$392.65</p>
35363	<p>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</p> <p><i>(foreign body does not include an instrument inserted for the purpose of a service being rendered)</i> (Anaes.) (Assist.)</p> <p>Fee: \$419.40 Benefit: 75% = \$314.55</p>
INTERVENTIONAL RADIOLOGY PROCEDURES	
‡ 35400	<p>VERTEBROPLASTY, for the treatment of a painful osteoporotic vertebral compression fracture, where:</p> <p>(a) the patient to whom the service is provided has not had the pain arising from the vertebral compression fracture controlled by conservative medical therapy; and</p> <p>(b) diagnostic imaging has confirmed that vertebroplasty will be of benefit;</p> <p>in association with item 61109, 57341 or 57345. (Anaes.) (See para T8.43 of explanatory notes to this Category)</p> <p>Fee: \$583.90 Benefit: 75% = \$437.95 85% = \$520.00</p>
‡ 35402	<p>VERTEBROPLASTY, for the treatment of a painful metastatic deposit or multiple myeloma in a vertebral body, in association with item 61109, 57341 or 57345. (Anaes.) (See para T8.43 of explanatory notes to this Category)</p> <p>Fee: \$583.90 Benefit: 75% = \$437.95 85% = \$520.00</p>

OPERATIONS	GYNAECOLOGICAL
35404	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective internal radiation therapy of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies The procedure must be performed by a specialist or consultant physician recognised in the specialties of nuclear medicine or radiation oncology on an admitted patient in a hospital. To be claimed once in the patient's lifetime only. <i>(See para T8.44 of explanatory notes to this Category)</i> Fee: \$306.30 Benefit: 75% = \$229.75
35406	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) <i>(See para T8.44 of explanatory notes to this Category)</i> Fee: \$718.65 Benefit: 75% = \$539.00
35408	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) <i>(See para T8.44 of explanatory notes to this Category)</i> Fee: \$539.10 Benefit: 75% = \$404.35
† 35410	UTERINE ARTERY CATHETERISATION with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) <i>(See para T8.36 of explanatory notes to this Category)</i> Fee: \$718.65 Benefit: 75% = \$539.00 85% = \$654.75
† 35412	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling if performed, with parent artery preservation, not for use with liquid embolics only, including intra-operative imaging, but in association with pre-operative diagnostic imaging items 60009 and either 60072, 60075 or 60078, including aftercare (Anaes.) (Assist.) <i>(See para T8.37 of explanatory notes to this Category)</i> Fee: \$2,525.05 Benefit: 75% = \$1,893.80 85% = \$2,461.15
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: \$71.80 Benefit: 75% = \$53.85 85% = \$61.05
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: \$70.85 Benefit: 75% = \$53.15 85% = \$60.25
35503	INTRAUTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$47.30 Benefit: 75% = \$35.50 85% = \$40.25
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: \$47.45 Benefit: 75% = \$35.60 85% = \$40.35
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: \$154.20 Benefit: 75% = \$115.65 85% = \$131.10
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: \$227.05 Benefit: 75% = \$170.30 85% = \$193.00
35509	HYMENECTOMY (Anaes.) Fee: \$79.10 Benefit: 75% = \$59.35 85% = \$67.25

OPERATIONS		GYNAECOLOGICAL	
35512 G 35513 S	BARTHOLIN'S CYST, excision of (Anaes.) Fee: \$158.50 Benefit: 75% = \$118.90	85% = \$134.75 85% = \$166.60	
35516 G 35517 S	BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes.) Fee: \$102.85 Benefit: 75% = \$77.15	85% = \$87.45 85% = \$109.65	
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: \$183.65 Benefit: 75% = \$137.75	85% = \$156.15	
35520	BARTHOLIN'S ABSCESS, incision of (Anaes.) Fee: \$51.50 Benefit: 75% = \$38.65	85% = \$43.80	
35523	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.) Fee: \$51.50 Benefit: 75% = \$38.65	85% = \$43.80	
35526 G 35527 S	URETHRAL CARUNCLE, excision of (Anaes.) Fee: \$102.85 Benefit: 75% = \$77.15	85% = \$87.45 85% = \$109.65	
35530	CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.) Fee: \$238.40 Benefit: 75% = \$178.80		
35533	VULVOPLASTY or LABIOPLASTY, where medically indicated, not being a service associated with a service to which item 35536 applies (Anaes.) Fee: \$309.15 Benefit: 75% = \$231.90	85% = \$262.80	
35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.) (Assist.) Fee: \$307.90 Benefit: 75% = \$230.95	85% = \$261.75	
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: \$241.20 Benefit: 75% = \$180.90	85% = \$205.05	
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: \$282.40 Benefit: 75% = \$211.80	85% = \$240.05	
35545	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes.) Fee: \$162.30 Benefit: 75% = \$121.75	85% = \$138.00	
35548	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.) Fee: \$737.05 Benefit: 75% = \$552.80		
35551	PELVIC LYMPH GLANDS, excision of (radical) (Anaes.) (Assist.) Fee: \$604.30 Benefit: 75% = \$453.25		
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.) Fee: \$38.45 Benefit: 75% = \$28.85	85% = \$32.70	
35557	VAGINA, removal of simple tumour (including Gartner duct cyst) (Anaes.) Fee: \$189.55 Benefit: 75% = \$142.20	85% = \$161.15	
35560	VAGINA, partial or complete removal of (Anaes.) (Assist.) Fee: \$604.30 Benefit: 75% = \$453.25		
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (Anaes.) (Assist.) Fee: \$1,219.05 Benefit: 75% = \$914.30		
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,000.85 Benefit: 75% = \$750.65		

OPERATIONS	GYNAECOLOGICAL
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.) Fee: \$462.05 Benefit: 75% = \$346.55
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) Fee: \$604.30 Benefit: 75% = \$453.25
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30
35568	SACROSPINOUS COLPOPEXY FOR MANAGEMENT OF UPPER VAGINAL PROLAPSE (Anaes.) (Assist.) Fee: \$551.95 Benefit: 75% = \$414.00
35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.) Fee: \$142.10 Benefit: 75% = \$106.60 85% = \$120.80
35570	ANTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving repair of urethrocoele and cystocele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) Fee: \$489.45 Benefit: 75% = \$367.10
35571	POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving one or more of the following; repair of perineum, rectocele or enterocele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) Fee: \$489.45 Benefit: 75% = \$367.10
35572	COLPOTOMY not being a service to which another item in this Group applies (Anaes.) Fee: \$109.40 Benefit: 75% = \$82.05
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: \$734.20 Benefit: 75% = \$550.65
35577	MANCHESTER (DONALD FOTHERGILL) OPERATION for genital prolapse, with or without mesh (Anaes.) (Assist.) Fee: \$596.00 Benefit: 75% = \$447.00
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: \$596.00 Benefit: 75% = \$447.00
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: \$1,020.60 Benefit: 75% = \$765.45
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: \$604.30 Benefit: 75% = \$453.25
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: \$1,301.80 Benefit: 75% = \$976.35
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: \$596.00 Benefit: 75% = \$447.00
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: \$596.00 Benefit: 75% = \$447.00
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: \$323.35 Benefit: 75% = \$242.55 85% = \$274.85
35608	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.) Fee: \$56.50 Benefit: 75% = \$42.40 85% = \$48.05

OPERATIONS		GYNAECOLOGICAL	
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: \$56.50	Benefit: 75% = \$42.40	85% = \$48.05
35612	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.) Fee: \$447.10	Benefit: 75% = \$335.35	85% = \$383.20
35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.) Fee: \$357.70	Benefit: 75% = \$268.30	
35614	EXAMINATION OF LOWER FEMALE GENITAL TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.) <i>(See para T8.47 of explanatory notes to this Category)</i> Fee: \$56.40	Benefit: 75% = \$42.30	85% = \$47.95
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies Fee: \$47.45	Benefit: 75% = \$35.60	85% = \$40.35
35616	ENDOMETRIUM, endoscopic examination of and ablation of, by microwave or thermal balloon or radiofrequency electrosurgery, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.) Fee: \$397.25	Benefit: 75% = \$297.95	
35617 G 35618 S	CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35577 or 35578 applies (Anaes.) Fee: \$153.45 Fee: \$192.60	Benefit: 75% = \$115.10 Benefit: 75% = \$144.45	85% = \$130.45 85% = \$163.75
35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.) Fee: \$47.10	Benefit: 75% = \$35.35	85% = \$40.05
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: \$532.35	Benefit: 75% = \$399.30	
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: \$723.90	Benefit: 75% = \$542.95	
35626	HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies <i>(See para T8.48 of explanatory notes to this Category)</i> Fee: \$73.20	Benefit: 75% = \$54.90	85% = \$62.25
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: \$94.65	Benefit: 75% = \$71.00	
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: \$161.75	Benefit: 75% = \$121.35	85% = \$137.50
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: \$192.60	Benefit: 75% = \$144.45	85% = \$163.75
35634	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.) Fee: \$605.90	Benefit: 75% = \$454.45	85% = \$542.00
35635	HYSTEROSCOPY involving resection of the uterine septum (Anaes.) Fee: \$264.65	Benefit: 75% = \$198.50	

OPERATIONS		GYNAECOLOGICAL	
35636	HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.) Fee: \$382.65 Benefit: 75% = \$287.00		
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: \$359.35 Benefit: 75% = \$269.55		
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: \$628.70 Benefit: 75% = \$471.55		
35639 G 35640 S	UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day hospital facility, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.) <i>(See para T8.49 of explanatory notes to this Category)</i> Fee: \$119.25 Benefit: 75% = \$89.45 Fee: \$161.75 Benefit: 75% = \$121.35		
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: \$1,098.10 Benefit: 75% = \$823.60		
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: \$192.60 Benefit: 75% = \$144.45 85% = \$163.75		
35644	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35639, 35640 or 35647 applies (Anaes.) <i>(See para T8.50 of explanatory notes to this Category)</i> Fee: \$179.95 Benefit: 75% = \$135.00 85% = \$153.00		
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.) <i>(See para T8.50 of explanatory notes to this Category)</i> Fee: \$281.65 Benefit: 75% = \$211.25 85% = \$239.45		
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.) <i>(See para T8.50 of explanatory notes to this Category)</i> Fee: \$179.95 Benefit: 75% = \$135.00 85% = \$153.00		
35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.) <i>(See para T8.50 of explanatory notes to this Category)</i> Fee: \$179.95 Benefit: 75% = \$135.00 85% = \$153.00		
35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.) <i>(See para T8.50 of explanatory notes to this Category)</i> Fee: \$281.65 Benefit: 75% = \$211.25 85% = \$239.45		
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.) Fee: \$473.65 Benefit: 75% = \$355.25		
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.) Fee: \$596.15 Benefit: 75% = \$447.15		

OPERATIONS	GYNAECOLOGICAL
35657	<p>HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies</p> <p>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 T8.51 of explanatory notes to this Category)</p> <p>Fee: \$596.15 Benefit: 75% = \$447.15</p>
35658	<p>UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.) (Assist.) (See para T8.52 of explanatory notes to this Category)</p> <p>Fee: \$367.60 Benefit: 75% = \$275.70</p>
35661	<p>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.)</p> <p>Fee: \$769.95 Benefit: 75% = \$577.50</p>
35664	<p>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.)</p> <p>Fee: \$1,283.20 Benefit: 75% = \$962.40</p>
35667	<p>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.)</p> <p>Fee: \$1,090.60 Benefit: 75% = \$817.95</p>
35670	<p>HYSTERECTOMY, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Anaes.) (Assist.)</p> <p>Fee: \$898.05 Benefit: 75% = \$673.55</p>
35673	<p>HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.)</p> <p>Fee: \$669.55 Benefit: 75% = \$502.20</p>
35674	<p>ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy</p> <p>Fee: \$183.65 Benefit: 75% = \$137.75 85% = \$156.15</p>
35676 G 35677 S	<p>ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.)</p> <p>Fee: \$375.50 Benefit: 75% = \$281.65</p> <p>Fee: \$473.65 Benefit: 75% = \$355.25</p>
35678	<p>ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.)</p> <p>Fee: \$571.05 Benefit: 75% = \$428.30</p>
35680	<p>BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.)</p> <p>Fee: \$514.35 Benefit: 75% = \$385.80 85% = \$450.45</p>
35683 G 35684 S	<p>UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.)</p> <p>Fee: \$310.40 Benefit: 75% = \$232.80</p> <p>Fee: \$416.35 Benefit: 75% = \$312.30</p>
35687 G 35688 S	<p>STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method.</p> <p>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 T8.51 of explanatory notes to this Category)</p> <p>Fee: \$287.40 Benefit: 75% = \$215.55</p> <p>Fee: \$351.05 Benefit: 75% = \$263.30</p>

OPERATIONS	GYNAECOLOGICAL
35691	<p>STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section</p> <p>NOTE: <i>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.</i> (Anaes.) (Assist.) (See para T8.51 of explanatory notes to this Category)</p> <p>Fee: \$140.25 Benefit: 75% = \$105.20</p>
35694	<p>TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)</p> <p>Fee: \$563.50 Benefit: 75% = \$422.65</p>
35697	<p>MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)</p> <p>Fee: \$836.10 Benefit: 75% = \$627.10</p>
35700	<p>FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope, for other than reversal of previous sterilisation (Anaes.) (Assist.) (See para T8.53 of explanatory notes to this Category)</p> <p>Fee: \$645.15 Benefit: 75% = \$483.90</p>
35703	<p>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.)</p> <p>Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75</p>
35706	<p>RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes.)</p> <p>Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75</p>
35709	<p>FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes.)</p> <p>Fee: \$38.45 Benefit: 75% = \$28.85 85% = \$32.70</p>
35710	<p>FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.)</p> <p>Fee: \$409.40 Benefit: 75% = \$307.05</p>
35712 G 35713 S	<p>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.)</p> <p>Fee: \$320.05 Benefit: 75% = \$240.05 Fee: \$400.20 Benefit: 75% = \$300.15</p>
35716 G 35717 S	<p>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.)</p> <p>Fee: \$383.80 Benefit: 75% = \$287.85 Fee: \$481.80 Benefit: 75% = \$361.35</p>
35720	<p>RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.) (See para T8.60 of explanatory notes to this Category)</p> <p>Fee: \$596.00 Benefit: 75% = \$447.00</p>
35723	<p>RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.)</p> <p>Fee: \$426.90 Benefit: 75% = \$320.20</p>
35726	<p>INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.)</p> <p>Fee: \$426.90 Benefit: 75% = \$320.20</p>
35729	<p>OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.)</p> <p>Fee: \$192.45 Benefit: 75% = \$144.35</p>
35750	<p>LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.)</p> <p>Fee: \$693.30 Benefit: 75% = \$520.00</p>

OPERATIONS	UROLOGICAL
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: \$766.65 Benefit: 75% = \$575.00
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: \$964.80 Benefit: 75% = \$723.60
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.) Fee: \$693.30 Benefit: 75% = \$520.00
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: \$497.75 Benefit: 75% = \$373.35
SUBGROUP 5 - UROLOGICAL	
GENERAL	
36500	ADRENAL GLAND, excision of partial or total (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) Fee: \$604.30 Benefit: 75% = \$453.25
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) Fee: \$1,229.30 Benefit: 75% = \$922.00
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) Fee: \$691.90 Benefit: 75% = \$518.95
36516	NEPHRECTOMY, complete (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
36519	NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.) Fee: \$1,140.90 Benefit: 75% = \$855.70
36522	NEPHRECTOMY, partial (Anaes.) (Assist.) Fee: \$979.05 Benefit: 75% = \$734.30
36525	NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.) Fee: \$1,391.25 Benefit: 75% = \$1,043.45
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.) <i>(See para T8.54 of explanatory notes to this Category)</i> Fee: \$1,140.90 Benefit: 75% = \$855.70 85% = \$1,077.00
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.) <i>(See para T8.54 of explanatory notes to this Category)</i> Fee: \$1,408.00 Benefit: 75% = \$1,056.00 85% = \$1,344.10
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: \$1,140.90 Benefit: 75% = \$855.70

OPERATIONS	UROLOGICAL
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: \$1,408.00 Benefit: 75% = \$1,056.00
36531	NEPHROURETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) Fee: \$1,023.10 Benefit: 75% = \$767.35
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: \$1,468.50 Benefit: 75% = \$1,101.40
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: \$1,735.60 Benefit: 75% = \$1,301.70
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: \$610.95 Benefit: 75% = \$458.25
36540	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (Anaes.) (Assist.) Fee: \$979.05 Benefit: 75% = \$734.30 85% = \$915.15
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: \$1,140.90 Benefit: 75% = \$855.70 85% = \$1,077.00
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) Fee: \$610.95 Benefit: 75% = \$458.25 85% = \$547.05
36549	URETEROLITHOTOMY (Anaes.) (Assist.) Fee: \$736.15 Benefit: 75% = \$552.15
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) Fee: \$655.25 Benefit: 75% = \$491.45
36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) Fee: \$574.20 Benefit: 75% = \$430.65 85% = \$510.30
36561	RENAL BIOPSY (closed) (Anaes.) Fee: \$152.45 Benefit: 75% = \$114.35 85% = \$129.60
36564	PYELOPLASTY, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
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: \$898.05 Benefit: 75% = \$673.55
36570	PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (Anaes.) (Assist.) Fee: \$1,140.90 Benefit: 75% = \$855.70
36573	DIVIDED URETER, repair of (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
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: \$1,023.10 Benefit: 75% = \$767.35
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: \$655.25 Benefit: 75% = \$491.45

OPERATIONS		UROLOGICAL
36585	URETER, transplantation of, into skin (Anaes.) (Assist.) Fee: \$655.25 Benefit: 75% = \$491.45	
36588	URETER, reimplantation into bladder (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80	
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) Fee: \$979.05 Benefit: 75% = \$734.30	
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80	
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80	
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) Fee: \$979.05 Benefit: 75% = \$734.30 85% = \$915.15	
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) Fee: \$1,140.90 Benefit: 75% = \$855.70	
36604	URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.) Fee: \$236.50 Benefit: 75% = \$177.40 85% = \$201.05	
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: \$610.25 Benefit: 75% = \$457.70	
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) Fee: \$2,046.35 Benefit: 75% = \$1,534.80	
36607	URETERIC STENT insertion of, with balloon 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: \$610.25 Benefit: 75% = \$457.70	
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: \$236.50 Benefit: 75% = \$177.40	
36609	INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.) Fee: \$655.25 Benefit: 75% = \$491.45	
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) Fee: \$574.20 Benefit: 75% = \$430.65	
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: \$655.25 Benefit: 75% = \$491.45	
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) Fee: \$574.20 Benefit: 75% = \$430.65	
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) Fee: \$410.45 Benefit: 75% = \$307.85	
36624	NEPHROSTOMY, percutaneous, using interventional imaging techniques (Anaes.) (Assist.) Fee: \$493.15 Benefit: 75% = \$369.90 85% = \$429.25	

OPERATIONS	UROLOGICAL
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: \$610.95 Benefit: 75% = \$458.25
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: \$301.80 Benefit: 75% = \$226.35
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: \$655.25 Benefit: 75% = \$491.45 85% = \$591.35
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: \$353.40 Benefit: 75% = \$265.05
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: \$736.15 Benefit: 75% = \$552.15
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: \$368.00 Benefit: 75% = \$276.00
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: \$942.20 Benefit: 75% = \$706.65
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: \$839.15 Benefit: 75% = \$629.40
36649	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (Anaes.) (Assist.) Fee: \$236.50 Benefit: 75% = \$177.40 85% = \$201.05
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: \$132.25 Benefit: 75% = \$99.20
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: \$574.20 Benefit: 75% = \$430.65
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: \$736.15 Benefit: 75% = \$552.15
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: \$942.20 Benefit: 75% = \$706.65
OPERATIONS ON THE BLADDER (CLOSED)	
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) Fee: \$24.40 Benefit: 75% = \$18.30 85% = \$20.75

OPERATIONS	UROLOGICAL
36803	<p>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 T8.57 of explanatory notes to this Category)</p> <p>Fee: \$412.10 Benefit: 75% = \$309.10 85% = \$350.30</p>
36806	<p>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.)</p> <p>Fee: \$574.20 Benefit: 75% = \$430.65</p>
36809	<p>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.)</p> <p>Fee: \$736.15 Benefit: 75% = \$552.15</p>
36811	<p>CYSTOSCOPY with insertion of urethral prosthesis (Anaes.)</p> <p>Fee: \$285.80 Benefit: 75% = \$214.35 85% = \$242.95</p>
36812	<p>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.)</p> <p>Fee: \$147.30 Benefit: 75% = \$110.50 85% = \$125.25</p>
36815	<p>CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or urethral warts, not being a service associated with a service to which item 30189 applies (Anaes.) (See para T8.13 of explanatory notes to this Category)</p> <p>Fee: \$210.20 Benefit: 75% = \$157.65 85% = \$178.70</p>
36818	<p>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.)</p> <p>Fee: \$244.40 Benefit: 75% = \$183.30 85% = \$207.75</p>
36821	<p>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.)</p> <p>Fee: \$285.60 Benefit: 75% = \$214.20 85% = \$242.80</p>
36824	<p>CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.)</p> <p>Fee: \$188.30 Benefit: 75% = \$141.25 85% = \$160.10</p>
36825	<p>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.)</p> <p>Fee: \$513.65 Benefit: 75% = \$385.25</p>
36827	<p>CYSTOSCOPY, with controlled hydrodilatation of the bladder (Anaes.)</p> <p>Fee: \$203.15 Benefit: 75% = \$152.40 85% = \$172.70</p>
36830	<p>CYSTOSCOPY, with ureteric meatotomy (Anaes.)</p> <p>Fee: \$179.65 Benefit: 75% = \$134.75</p>
36833	<p>CYSTOSCOPY, with removal of ureteric stent or other foreign body (Anaes.) (Assist.)</p> <p>Fee: \$244.40 Benefit: 75% = \$183.30 85% = \$207.75</p>
36836	<p>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.)</p> <p>Fee: \$203.15 Benefit: 75% = \$152.40 85% = \$172.70</p>
36840	<p>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.)</p> <p>Fee: \$285.60 Benefit: 75% = \$214.20 85% = \$242.80</p>
36842	<p>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.)</p> <p>Fee: \$287.40 Benefit: 75% = \$215.55</p>

OPERATIONS	UROLOGICAL
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: \$610.95 Benefit: 75% = \$458.25 85% = \$547.05
36848	CYSTOSCOPY, with resection of ureterocele (Anaes.) Fee: \$203.15 Benefit: 75% = \$152.40
36851	CYSTOSCOPY, with injection into bladder wall (Anaes.) Fee: \$203.15 Benefit: 75% = \$152.40
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) Fee: \$412.10 Benefit: 75% = \$309.10
36857	ENDOSCOPIC MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.) Fee: \$323.80 Benefit: 75% = \$242.85
36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes.) Fee: \$147.30 Benefit: 75% = \$110.50 85% = \$125.25
36863	LITHOLAPAXY, with or without cystoscopy (Anaes.) (Assist.) Fee: \$412.10 Benefit: 75% = \$309.10
OPERATIONS ON THE BLADDER (OPEN)	
37000	BLADDER, partial excision of (Anaes.) (Assist.) Fee: \$655.25 Benefit: 75% = \$491.45
37004	BLADDER, repair of rupture (Anaes.) (Assist.) Fee: \$574.20 Benefit: 75% = \$430.65
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: \$368.00 Benefit: 75% = \$276.00 85% = \$312.80
37011	SUPRAPUBIC STAB CYSTOTOMY, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.) Fee: \$82.45 Benefit: 75% = \$61.85 85% = \$70.10
37014	BLADDER, total excision of (Anaes.) (Assist.) Fee: \$942.20 Benefit: 75% = \$706.65
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) Fee: \$655.25 Benefit: 75% = \$491.45
37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) Fee: \$368.00 Benefit: 75% = \$276.00
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) Fee: \$368.00 Benefit: 75% = \$276.00
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) Fee: \$611.30 Benefit: 75% = \$458.50
37041	BLADDER ASPIRATION by needle Fee: \$41.20 Benefit: 75% = \$30.90 85% = \$35.05
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: \$805.25 Benefit: 75% = \$603.95
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: \$596.00 Benefit: 75% = \$447.00

OPERATIONS	UROLOGICAL
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: \$611.30 Benefit: 75% = \$458.50
37045	MITROFANOFF CONTINENT VALVE, formation of (Anaes.) (Assist.) Fee: \$1,262.50 Benefit: 75% = \$946.90
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) Fee: \$1,472.20 Benefit: 75% = \$1,104.15
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) Fee: \$655.25 Benefit: 75% = \$491.45
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) Fee: \$757.05 Benefit: 75% = \$567.80
OPERATIONS ON THE PROSTATE	
37200	PROSTATECTOMY, open (Anaes.) (Assist.) Fee: \$898.05 Benefit: 75% = \$673.55
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.) <i>(See para T8.56 of explanatory notes to this Category)</i> Fee: \$732.45 Benefit: 75% = \$549.35
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.) <i>(See para T8.56 of explanatory notes to this Category)</i> Fee: \$367.60 Benefit: 75% = \$275.70 85% = \$312.50
37203	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, <u>37201</u> , <u>37202</u> , 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) Fee: \$920.85 Benefit: 75% = \$690.65
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 <u>37201</u> , 37203, 37207 or which had to be discontinued for medical reasons (Anaes.) Fee: \$493.15 Benefit: 75% = \$369.90
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, <u>37201</u> , <u>37202</u> , 37203, 37206, 37321 or 37324 applies (Anaes.) Fee: \$765.65 Benefit: 75% = \$574.25
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 <u>37201</u> , 37203, 37207 or which had to be discontinued for medical reasons (Anaes.) Fee: \$367.60 Benefit: 75% = \$275.70
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: \$1,140.90 Benefit: 75% = \$855.70
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: \$1,408.00 Benefit: 75% = \$1,056.00
37211	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, <i>with pelvic lymphadenectomy</i> , not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.) Fee: \$1,710.05 Benefit: 75% = \$1,282.55

OPERATIONS	UROLOGICAL
37212	PROSTATE, open perineal biopsy or open drainage of abscess (Anaes.) (Assist.) Fee: \$244.40 Benefit: 75% = \$183.30
37215	PROSTATE, biopsy of, endoscopic, with or without cystoscopy (Anaes.) (Assist.) Fee: \$368.00 Benefit: 75% = \$276.00 85% = \$312.80
37218	PROSTATE, needle biopsy of, or injection into (Anaes.) Fee: \$122.20 Benefit: 75% = \$91.65 85% = \$103.90
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: \$248.15 Benefit: 75% = \$186.15 85% = \$210.95
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. <i>(See para T8.58 of explanatory notes to this Category)</i> Fee: \$922.70 Benefit: 75% = \$692.05
37221	PROSTATIC ABSCESS, endoscopic drainage of (Anaes.) (Assist.) Fee: \$412.10 Benefit: 75% = \$309.10
37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.) Fee: \$182.25 Benefit: 75% = \$136.70
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: \$285.60 Benefit: 75% = \$214.20 85% = \$242.80
† 37227	PROSTATE, transperineal insertion of catheters into, for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy. The procedure must be performed at an approved site in association with a radiation oncologist, and be associated with a service to which item 15327 or 15328 applies. (Anaes.) <i>(See para T8.59 of explanatory notes to this Category)</i> Fee: \$500.00 Benefit: 75% = \$375.00 85% = \$436.10
37230	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) Fee: \$920.85 Benefit: 75% = \$690.65 85% = \$856.95
37233	PROSTATE, high-energy transurethral microwave thermotherapy of, 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, 37207, 37230 which had to be discontinued for medical reasons (Anaes.) Fee: \$493.15 Benefit: 75% = \$369.90 85% = \$429.25
OPERATIONS ON URETHRA, PENIS OR SCROTUM	
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) Fee: \$41.20 Benefit: 75% = \$30.90 85% = \$35.05
37303	URETHRAL STRICTURE, dilatation of (Anaes.) Fee: \$65.45 Benefit: 75% = \$49.10 85% = \$55.65
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) Fee: \$574.20 Benefit: 75% = \$430.65
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
37315	URETHROSCOPY, as an independent procedure (Anaes.) Fee: \$122.20 Benefit: 75% = \$91.65 85% = \$103.90
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: \$244.40 Benefit: 75% = \$183.30 85% = \$207.75

OPERATIONS	UROLOGICAL
37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.) Fee: \$82.45 Benefit: 75% = \$61.85 85% = \$70.10
37324	URETHROTOMY OR URETHROSTOMY, internal or external (Anaes.) Fee: \$203.15 Benefit: 75% = \$152.40
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) Fee: \$285.60 Benefit: 75% = \$214.20
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) Fee: \$574.20 Benefit: 75% = \$430.65
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) Fee: \$493.15 Benefit: 75% = \$369.90
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) Fee: \$655.25 Benefit: 75% = \$491.45
37339	PERIURETHRAL OR TRANSURETHRAL INJECTION of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy (Anaes.) Fee: \$211.95 Benefit: 75% = \$159.00 85% = \$180.20
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: \$375.50 Benefit: 75% = \$281.65
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: \$805.25 Benefit: 75% = \$603.95
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.) Fee: \$736.15 Benefit: 75% = \$552.15
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: \$1,229.30 Benefit: 75% = \$922.00
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) Fee: \$610.95 Benefit: 75% = \$458.25
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) Fee: \$610.95 Benefit: 75% = \$458.25
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$244.40 Benefit: 75% = \$183.30
37354	HYPOSPADIAS, meatotomy and hemircumcision (Anaes.) (Assist.) Fee: \$285.60 Benefit: 75% = \$214.20
37369	URETHRA, excision of prolapse of (Anaes.) Fee: \$164.85 Benefit: 75% = \$123.65
37372	URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.) Fee: \$412.10 Benefit: 75% = \$309.10
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) Fee: \$1,023.10 Benefit: 75% = \$767.35
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) Fee: \$655.25 Benefit: 75% = \$491.45
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) Fee: \$1,023.10 Benefit: 75% = \$767.35

OPERATIONS	UROLOGICAL
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) Fee: \$285.60 Benefit: 75% = \$214.20
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
37393	PRIAPISM, decompression by glanular stab cavernospongiosum shunt or penile aspiration with or without lavage (Anaes.) Fee: \$203.15 Benefit: 75% = \$152.40 85% = \$172.70
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) Fee: \$655.25 Benefit: 75% = \$491.45
37402	PENIS, partial amputation of (Anaes.) (Assist.) Fee: \$412.10 Benefit: 75% = \$309.10
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) Fee: \$412.10 Benefit: 75% = \$309.10
37411	PENIS, repair of avulsion (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80 85% = \$753.15
37415	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months Fee: \$41.20 Benefit: 75% = \$30.90 85% = \$35.05
37417	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes.) (Assist.) Fee: \$493.15 Benefit: 75% = \$369.90
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: \$655.25 Benefit: 75% = \$491.45 85% = \$591.35
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: \$323.80 Benefit: 75% = \$242.85
37423	PENIS, lengthening by translocation of corpora (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) Fee: \$861.15 Benefit: 75% = \$645.90
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) Fee: \$285.60 Benefit: 75% = \$214.20
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
37435	PENIS, frenuloplasty as an independent procedure (Anaes.) Fee: \$82.45 Benefit: 75% = \$61.85 85% = \$70.10
37438	SCROTUM, partial excision of (Anaes.) (Assist.) Fee: \$244.40 Benefit: 75% = \$183.30 85% = \$207.75
37444	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.) Fee: \$883.30 Benefit: 75% = \$662.50 85% = \$819.40
OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES	
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) Fee: \$244.40 Benefit: 75% = \$183.30 85% = \$207.75

OPERATIONS	UROLOGICAL
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: \$244.40 Benefit: 75% = \$183.30 85% = \$207.75
37607	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (Anaes.) (Assist.) Fee: \$817.05 Benefit: 75% = \$612.80
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: \$1,229.30 Benefit: 75% = \$922.00
37613	EPIDIDYMECTOMY (Anaes.) Fee: \$244.40 Benefit: 75% = \$183.30 85% = \$207.75
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.) <i>(See para T8.53 of explanatory notes to this Category)</i> Fee: \$610.95 Benefit: 75% = \$458.25
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.) <i>(See para T8.53 of explanatory notes to this Category)</i> Fee: \$244.40 Benefit: 75% = \$183.30 85% = \$207.75
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.) <i>(See para T8.51 of explanatory notes to this Category)</i> Fee: \$170.75 Benefit: 75% = \$128.10 85% = \$145.15 Fee: \$203.15 Benefit: 75% = \$152.40 85% = \$172.70
PAEDIATRIC GENITOURINARY SURGERY	
37800	PATENT URACHUS, excision of (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45
37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Anaes.) (Assist.) Fee: \$532.15 Benefit: 75% = \$399.15 85% = \$468.25
37809	UNDESCENDED TESTIS, revision orchidopexy for (Anaes.) (Assist.) Fee: \$532.15 Benefit: 75% = \$399.15
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: \$491.35 Benefit: 75% = \$368.55
37815	HYPOSPADIAS, examination under anaesthesia with erection test (Anaes.) Fee: \$81.90 Benefit: 75% = \$61.45
37818	HYPOSPADIAS, glanuloplasty incorporating meatal advancement (Anaes.) (Assist.) Fee: \$434.30 Benefit: 75% = \$325.75 85% = \$370.40
37821	HYPOSPADIAS, distal, 1 stage repair (Anaes.) (Assist.) Fee: \$736.15 Benefit: 75% = \$552.15
37824	HYPOSPADIAS, proximal, 1 stage repair (Anaes.) (Assist.) Fee: \$1,023.55 Benefit: 75% = \$767.70
37827	HYPOSPADIAS, staged repair, first stage (Anaes.) (Assist.) Fee: \$471.50 Benefit: 75% = \$353.65

OPERATIONS		CARDIO-THORACIC
37830	HYPOSPADIAS, staged repair, second stage (Anaes.) (Assist.) Fee: \$610.95 Benefit: 75% = \$458.25 85% = \$547.05	
37833	HYPOSPADIAS, repair of post operative urethral fistula (Anaes.) (Assist.) Fee: \$291.60 Benefit: 75% = \$218.70	
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) Fee: \$614.20 Benefit: 75% = \$460.65	
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) Fee: \$695.95 Benefit: 75% = \$522.00	
37842	EXSTROPHY OF BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) Fee: \$1,351.20 Benefit: 75% = \$1,013.40	
37845	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.) Fee: \$614.20 Benefit: 75% = \$460.65	
37848	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) Fee: \$1,105.45 Benefit: 75% = \$829.10	
37851	CONGENITAL ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) Fee: \$818.95 Benefit: 75% = \$614.25	
37854	URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.) Fee: \$323.80 Benefit: 75% = \$242.85	
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: \$393.60 Benefit: 75% = \$295.20 85% = \$334.60	
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: \$469.65 Benefit: 75% = \$352.25 85% = \$405.75	
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: \$567.85 Benefit: 75% = \$425.90 85% = \$503.95	
38209	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.) <i>(See para T8.61 of explanatory notes to this Category)</i> Fee: \$729.05 Benefit: 75% = \$546.80 85% = \$665.15	
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.) <i>(See para T8.61 of explanatory notes to this Category)</i> Fee: \$1,212.75 Benefit: 75% = \$909.60 85% = \$1,148.85	
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: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00	

OPERATIONS		CARDIO-THORACIC
38215	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.55 of explanatory notes to this Category)</p> <p>Fee: \$392.00 Benefit: 75% = \$294.00 85% = \$333.20</p>	
38218	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.55 of explanatory notes to this Category)</p> <p>Fee: \$587.95 Benefit: 75% = \$441.00 85% = \$524.05</p>	
38220	<p>SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.55 of explanatory notes to this Category)</p> <p>Fee: \$196.00 Benefit: 75% = \$147.00 85% = \$166.60</p>	
38222	<p>SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.55 of explanatory notes to this Category)</p> <p>Fee: \$392.00 Benefit: 75% = \$294.00 85% = \$333.20</p>	
38225	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.55 of explanatory notes to this Category)</p> <p>Fee: \$588.00 Benefit: 75% = \$441.00 85% = \$524.10</p>	
38228	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.55 of explanatory notes to this Category)</p> <p>Fee: \$784.05 Benefit: 75% = \$588.05 85% = \$720.15</p>	
38231	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.55 of explanatory notes to this Category)</p> <p>Fee: \$980.00 Benefit: 75% = \$735.00 85% = \$916.10</p>	
38234	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.) (See para T8.55 of explanatory notes to this Category)</p> <p>Fee: \$783.95 Benefit: 75% = \$588.00 85% = \$720.05</p>	
38237	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.) (See para T8.55 of explanatory notes to this Category)</p> <p>Fee: \$979.95 Benefit: 75% = \$735.00 85% = \$916.05</p>	

OPERATIONS	CARDIO-THORACIC
38240	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.)</p> <p><i>(See para T8.55 of explanatory notes to this Category)</i></p> <p>Fee: \$1,175.90 Benefit: 75% = \$881.95 85% = \$1,112.00</p>
† 38241	<p>USE OF A CORONARY PRESSURE WIRE during selective coronary angiography to measure fractional flow reserve (FFR) and coronary flow reserve (CFR) in one or more intermediate coronary artery or graft lesions (stenosis of 30-70%), to determine whether revascularisation should be performed where previous stress testing has either not been performed or the results are inconclusive (Anaes.)</p> <p>Fee: \$415.00 Benefit: 75% = \$311.25 85% = \$352.75</p>
38243	<p>PLACEMENT OF CATHETER(S) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.)</p> <p><i>(See para T8.55 of explanatory notes to this Category)</i></p> <p>Fee: \$392.00 Benefit: 75% = \$294.00 85% = \$333.20</p>
38246	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.)</p> <p><i>(See para T8.55 of explanatory notes to this Category)</i></p> <p>Fee: \$979.95 Benefit: 75% = \$735.00 85% = \$916.05</p>
38256	<p>TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.)</p> <p>Fee: \$236.10 Benefit: 75% = \$177.10 85% = \$200.70</p>
38270	<p>BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.)</p> <p>Fee: \$806.15 Benefit: 75% = \$604.65 85% = \$742.25</p>
38272	<p>ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.)</p> <p>Fee: \$806.15 Benefit: 75% = \$604.65 85% = \$742.25</p>
38275	<p>MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.)</p> <p>Fee: \$263.50 Benefit: 75% = \$197.65 85% = \$224.00</p>
38285	<p>IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where:</p> <ul style="list-style-type: none"> - 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. <p>including initial programming and testing, as an admitted patient in an approved hospital or day-hospital facility (Anaes.)</p> <p><i>(See para T8.62 of explanatory notes to this Category)</i></p> <p>Fee: \$170.45 Benefit: 75% = \$127.85 85% = \$144.90</p>
38286	<p>IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital or day-hospital facility (Anaes.)</p> <p>Fee: \$153.50 Benefit: 75% = \$115.15 85% = \$130.50</p>
CATHETER BASED ARRHYTHMIA ABLATION	
38287	<p>ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.)</p> <p>Fee: \$1,854.20 Benefit: 75% = \$1,390.65 85% = \$1,790.30</p>
38290	<p>ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.)</p> <p>Fee: \$2,361.05 Benefit: 75% = \$1,770.80</p>
38293	<p>VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.)</p> <p>Fee: \$2,534.30 Benefit: 75% = \$1,900.75 85% = \$2,470.40</p>

OPERATIONS		CARDIO-THORACIC
ENDOVASCULAR INTERVENTIONAL PROCEDURES		
38300	<p>TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p>Fee: \$455.45 Benefit: 75% = \$341.60 85% = \$391.55</p>	
38303	<p>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.)</p> <p>Fee: \$583.90 Benefit: 75% = \$437.95 85% = \$520.00</p>	
‡ 38306	<p>TRANSLUMINAL INSERTION OF STENT OR STENTS into 1 occlusional site, including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p><i>(See para T8.63 of explanatory notes to this Category)</i></p> <p>Fee: \$673.70 Benefit: 75% = \$505.30 85% = \$609.80</p>	
38309	<p>PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with no stent insertion, where:</p> <ul style="list-style-type: none"> - 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; <p>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p><i>(See para T8.46 of explanatory notes to this Category)</i></p> <p>Fee: \$782.45 Benefit: 75% = \$586.85 85% = \$718.55</p>	
38312	<p>PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where:</p> <ul style="list-style-type: none"> - 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; <p>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p><i>(See para T8.46 of explanatory notes to this Category)</i></p> <p>Fee: \$1,000.65 Benefit: 75% = \$750.50 85% = \$936.75</p>	
38315	<p>PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where:</p> <ul style="list-style-type: none"> - 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; <p>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p><i>(See para T8.46 of explanatory notes to this Category)</i></p> <p>Fee: \$1,074.35 Benefit: 75% = \$805.80 85% = \$1,010.45</p>	
38318	<p>PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where:</p> <ul style="list-style-type: none"> - 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, <p>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p><i>(See para T8.46 of explanatory notes to this Category)</i></p> <p>Fee: \$1,401.75 Benefit: 75% = \$1,051.35 85% = \$1,337.85</p>	
38321	<p>CATHETER BASED INTRAVASCULAR BRACHYTHERAPY treatment of in-stent restenoses in 1 coronary artery, catheterisation for, including in the same artery;</p> <ul style="list-style-type: none"> - balloon angioplasty <p>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.)</p> <p><i>(See para T8.45 of explanatory notes to this Category)</i></p> <p>Fee: \$683.15 Benefit: 75% = \$512.40 85% = \$619.25</p>	

OPERATIONS	CARDIO-THORACIC
38324	<p>CATHETER BASED INTRAVASCULAR BRACHYTHERAPY treatment of in-stent restenoses in 1 coronary artery, catheterisation for, including in the same artery;</p> <ul style="list-style-type: none"> - balloon angioplasty - intravascular ultrasound <p>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 T8.45 of explanatory notes to this Category)</p> <p>Fee: \$910.20 Benefit: 75% = \$682.65 85% = \$846.30</p>
38327	<p>CATHETER BASED INTRAVASCULAR BRACHYTHERAPY treatment of in-stent restenoses in 1 coronary artery, catheterisation for, including in the same artery;</p> <ul style="list-style-type: none"> - balloon angioplasty - percutaneous transluminal rotational artherectomy <p>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 T8.45 of explanatory notes to this Category)</p> <p>Fee: \$1,010.15 Benefit: 75% = \$757.65 85% = \$946.25</p>
38330	<p>CATHETER BASED INTRAVASCULAR BRACHYTHERAPY treatment of in-stent restenoses in 1 coronary artery, catheterisation for, including in the same artery;</p> <ul style="list-style-type: none"> - balloon angioplasty - percutaneous transluminal rotational artherectomy - intravascular ultrasound <p>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 T8.45 of explanatory notes to this Category)</p> <p>Fee: \$1,237.85 Benefit: 75% = \$928.40 85% = \$1,173.95</p>
38350	<p style="text-align: center;">MISCELLANEOUS CARDIAC PROCEDURES</p> <p>SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of (Anaes.)</p> <p>Fee: \$564.40 Benefit: 75% = \$423.30</p>
38353	<p>PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy (Anaes.) (See para T8.61 of explanatory notes to this Category)</p> <p>Fee: \$225.75 Benefit: 75% = \$169.35</p>
38356	<p>DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of (Anaes.) (See para T8.61 of explanatory notes to this Category)</p> <p>Fee: \$739.90 Benefit: 75% = \$554.95</p>
38358	<p>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 T8.65 of explanatory notes to this Category)</p> <p>Fee: \$2,534.30 Benefit: 75% = \$1,900.75</p>
38359	<p>PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.)</p> <p>Fee: \$118.05 Benefit: 75% = \$88.55 85% = \$100.35</p>
38362	<p>INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.)</p> <p>Fee: \$340.10 Benefit: 75% = \$255.10 85% = \$289.10</p>
38365	<p>PERMANENT CARDIAC SYNCHRONISATION DEVICE, insertion, removal or replacement of, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria:</p> <ul style="list-style-type: none"> - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) <p>(See para T8.64 of explanatory notes to this Category)</p> <p>Fee: \$225.75 Benefit: 75% = \$169.35</p>

OPERATIONS		CARDIO-THORACIC
38368	<p>PERMANENT TRANSVENOUS LEFT VENTRICULAR ELECTRODE, insertion, removal or replacement of through the coronary sinus, for the purpose of cardiac resynchronisation therapy, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria:</p> <ul style="list-style-type: none"> - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. <p>Where the service includes right heart catheterisation and any associated venogram of left ventricular veins. Not being a service associated with a service to which items 38200 and 35200 apply (Anaes.) (See para T8.64 of explanatory notes to this Category)</p> <p>Fee: \$1,082.10 Benefit: 75% = \$811.60</p>	
† 38371	<p>PERMANENT CARDIAC SYNCHRONISATION DEVICE CAPABLE OF DEFIBRILLATION, insertion, removal or replacement of, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy who meet all of the following criteria:</p> <ul style="list-style-type: none"> - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) <p>(See para T8.66 of explanatory notes to this Category)</p> <p>Fee: \$254.35 Benefit: 75% = \$190.80 85% = \$216.20</p>	
† 38384	<p>AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in:</p> <ul style="list-style-type: none"> - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. <p>Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.)</p> <p>Fee: \$930.20 Benefit: 75% = \$697.65 85% = \$866.30</p>	
† 38387	<p>AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for, primary prevention of sudden cardiac death in:</p> <ul style="list-style-type: none"> - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. <p>Not being a service associated with a service to which item 38213 applies, not for defibrillators capable of cardiac resynchronisation therapy (Anaes.) (Assist.)</p> <p>Fee: \$254.35 Benefit: 75% = \$190.80 85% = \$216.20</p>	
‡ 38390	<p>AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.)</p> <p>Fee: \$930.20 Benefit: 75% = \$697.65 85% = \$866.30</p>	
‡ 38393	<p>AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies. (Anaes.) (Assist.)</p> <p>Fee: \$254.35 Benefit: 75% = \$190.80 85% = \$216.20</p>	
THORACIC SURGERY		
38415	<p>EMPHYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.)</p> <p>Fee: \$352.85 Benefit: 75% = \$264.65 85% = \$299.95</p>	
38418	<p>THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.)</p> <p>Fee: \$846.90 Benefit: 75% = \$635.20</p>	
38421	<p>THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.)</p> <p>Fee: \$1,353.75 Benefit: 75% = \$1,015.35</p>	
38424	<p>THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.)</p> <p>Fee: \$846.90 Benefit: 75% = \$635.20</p>	

OPERATIONS	CARDIO-THORACIC
38427	THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.) Fee: \$1,045.70 Benefit: 75% = \$784.30
38430	THORACOPLASTY (in stages) each stage (Anaes.) (Assist.) Fee: \$538.95 Benefit: 75% = \$404.25
38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.) Fee: \$220.70 Benefit: 75% = \$165.55
38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes.) (Assist.) Fee: \$1,353.75 Benefit: 75% = \$1,015.35
38440	LUNG, wedge resection of (Anaes.) (Assist.) Fee: \$1,013.70 Benefit: 75% = \$760.30
38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.) Fee: \$1,603.95 Benefit: 75% = \$1,203.00
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.) Fee: \$1,045.70 Benefit: 75% = \$784.30
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,353.75 Benefit: 75% = \$1,015.35
38448	MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.) Fee: \$320.80 Benefit: 75% = \$240.60
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,893.85 Benefit: 75% = \$1,420.40
38450	PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.) Fee: \$757.00 Benefit: 75% = \$567.75
38452	PERICARDIUM, sub-xyphoid drainage of (Anaes.) (Assist.) Fee: \$506.95 Benefit: 75% = \$380.25
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,520.65 Benefit: 75% = \$1,140.50
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$2,056.85 Benefit: 75% = \$1,542.65
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: \$1,353.75 Benefit: 75% = \$1,015.35
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.) Fee: \$1,263.85 Benefit: 75% = \$947.90
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.) Fee: \$673.70 Benefit: 75% = \$505.30
38460	STERNAL WIRE OR WIRES, removal of (Anaes.) Fee: \$243.35 Benefit: 75% = \$182.55
38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes.) Fee: \$288.40 Benefit: 75% = \$216.30
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: \$313.50 Benefit: 75% = \$235.15

OPERATIONS	CARDIO-THORACIC
38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.) Fee: \$846.55 Benefit: 75% = \$634.95
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.) Fee: \$1,304.45 Benefit: 75% = \$978.35
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.) Fee: \$1,520.65 Benefit: 75% = \$1,140.50
	CARDIAC SURGERY PROCEDURES <i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i>
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.) Fee: \$846.90 Benefit: 75% = \$635.20
38473	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.) Fee: \$506.95 Benefit: 75% = \$380.25
	VALVULAR PROCEDURES <i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i>
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: \$735.00 Benefit: 75% = \$551.25
38477	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.) Fee: \$1,770.25 Benefit: 75% = \$1,327.70
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.) Fee: \$857.55 Benefit: 75% = \$643.20
38480	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.) Fee: \$1,770.25 Benefit: 75% = \$1,327.70
38481	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.) Fee: \$2,015.30 Benefit: 75% = \$1,511.50
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: \$1,520.65 Benefit: 75% = \$1,140.50
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) Fee: \$722.05 Benefit: 75% = \$541.55
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) Fee: \$1,520.65 Benefit: 75% = \$1,140.50
38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.) Fee: \$1,687.40 Benefit: 75% = \$1,265.55
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.) Fee: \$2,006.80 Benefit: 75% = \$1,505.10
38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.) Fee: \$490.00 Benefit: 75% = \$367.50
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) Fee: \$1,729.85 Benefit: 75% = \$1,297.40

OPERATIONS	CARDIO-THORACIC
	<p style="text-align: center;">SURGERY FOR ISCHAEMIC HEART DISEASE</p> <p style="text-align: center;"><i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i></p>
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.) Fee: \$551.35 Benefit: 75% = \$413.55
38497	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service associated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.) <i>(See para T8.69 of explanatory notes to this Category)</i> Fee: \$1,809.30 Benefit: 75% = \$1,357.00
38498	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass , using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.) <i>(See para T8.69 of explanatory notes to this Category)</i> Fee: \$1,809.30 Benefit: 75% = \$1,357.00
38500	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Anaes.) (Assist.) <i>(See para T8.69 of explanatory notes to this Category)</i> Fee: \$1,944.00 Benefit: 75% = \$1,458.00
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.) <i>(See para T8.69 of explanatory notes to this Category)</i> Fee: \$1,944.00 Benefit: 75% = \$1,458.00
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.) <i>(See para T8.69 of explanatory notes to this Category)</i> Fee: \$2,110.75 Benefit: 75% = \$1,583.10
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.) <i>(See para T8.69 of explanatory notes to this Category)</i> Fee: \$2,110.75 Benefit: 75% = \$1,583.10
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.) (Assist.) Fee: \$245.00 Benefit: 75% = \$183.75
38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.) Fee: \$1,437.05 Benefit: 75% = \$1,077.80
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.) Fee: \$1,687.05 Benefit: 75% = \$1,265.30
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.) Fee: \$2,110.75 Benefit: 75% = \$1,583.10
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.) Fee: \$2,110.75 Benefit: 75% = \$1,583.10

OPERATIONS	CARDIO-THORACIC
	ARRHYTHMIA SURGERY <i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i>
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.) Fee: \$1,854.20 Benefit: 75% = \$1,390.65
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: \$2,361.05 Benefit: 75% = \$1,770.80
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.) Fee: \$2,534.30 Benefit: 75% = \$1,900.75
	PROCEDURES ON THE THORACIC AORTA <i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i>
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) Fee: \$1,896.45 Benefit: 75% = \$1,422.35
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) Fee: \$2,403.30 Benefit: 75% = \$1,802.50
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) Fee: \$2,743.45 Benefit: 75% = \$2,057.60
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) Fee: \$2,236.50 Benefit: 75% = \$1,677.40
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: \$2,743.45 Benefit: 75% = \$2,057.60
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: \$3,077.00 Benefit: 75% = \$2,307.75
‡ 38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endvascular means (Anaes.) (Assist.) Fee: \$1,646.15 Benefit: 75% = \$1,234.65
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,813.00 Benefit: 75% = \$1,359.75
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.) Fee: \$1,755.85 Benefit: 75% = \$1,316.90
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.) Fee: \$490.00 Benefit: 75% = \$367.50
	TECHNIQUES FOR PRESERVATION OF THE ARRESTED HEART <i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i>
38588	CANNULATION of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.) Fee: \$367.60 Benefit: 75% = \$275.70

OPERATIONS	CARDIO-THORACIC
	CIRCULATORY SUPPORT PROCEDURES <i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i>
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: \$1,353.75 Benefit: 75% = \$1,015.35
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes.) (Assist.) Fee: \$846.90 Benefit: 75% = \$635.20
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.) Fee: \$423.40 Benefit: 75% = \$317.55
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.) Fee: \$474.60 Benefit: 75% = \$355.95 85% = \$410.70
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.) Fee: \$595.70 Benefit: 75% = \$446.80
38615	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) Fee: \$1,353.75 Benefit: 75% = \$1,015.35
38618	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) Fee: \$1,687.40 Benefit: 75% = \$1,265.55
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) Fee: \$673.70 Benefit: 75% = \$505.30
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) Fee: \$757.00 Benefit: 75% = \$567.75
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: \$591.65 Benefit: 75% = \$443.75
	RE-OPERATION <i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i>
38637	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.) Fee: \$490.00 Benefit: 75% = \$367.50
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.) <i>(See para T8.70 of explanatory notes to this Category)</i> Fee: \$846.90 Benefit: 75% = \$635.20
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES <i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i>
38643	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) Fee: \$943.15 Benefit: 75% = \$707.40
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.) Fee: \$1,886.15 Benefit: 75% = \$1,414.65
38650	MYOMECTIONY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.) Fee: \$1,687.40 Benefit: 75% = \$1,265.55
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$1,687.40 Benefit: 75% = \$1,265.55

OPERATIONS	CARDIO-THORACIC
38654	<p>PERMANENT LEFT VENTRICULAR ELECTRODE, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria:</p> <ul style="list-style-type: none"> - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) (Assist.) <p>(See para T8.64 of explanatory notes to this Category)</p> <p>Fee: \$1,082.10 Benefit: 75% = \$811.60</p>
38656	<p>THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.)</p> <p>Fee: \$846.90 Benefit: 75% = \$635.20</p>
<p>CARDIAC TUMOURS</p> <p><i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i></p>	
38670	<p>CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.)</p> <p>Fee: \$1,687.05 Benefit: 75% = \$1,265.30</p>
38673	<p>CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.)</p> <p>Fee: \$1,898.85 Benefit: 75% = \$1,424.15</p>
38677	<p>CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.)</p> <p>Fee: \$1,776.40 Benefit: 75% = \$1,332.30</p>
38680	<p>CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.)</p> <p>Fee: \$2,107.10 Benefit: 75% = \$1,580.35 85% = \$2,043.20</p>
<p>CONGENITAL CARDIAC SURGERY</p> <p><i>The items in this group are to be performed by open exposure or minimally invasive surgery unless otherwise stated in the item descriptor</i></p>	
38700	<p>PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)</p> <p>Fee: \$943.15 Benefit: 75% = \$707.40</p>
38703	<p>PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)</p> <p>Fee: \$1,700.20 Benefit: 75% = \$1,275.15</p>
38706	<p>AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)</p> <p>Fee: \$1,610.35 Benefit: 75% = \$1,207.80</p>
38709	<p>AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)</p> <p>Fee: \$1,886.15 Benefit: 75% = \$1,414.65</p>
38712	<p>AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.)</p> <p>Fee: \$2,264.90 Benefit: 75% = \$1,698.70</p>
38715	<p>MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)</p> <p>Fee: \$1,507.75 Benefit: 75% = \$1,130.85</p>
38718	<p>MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)</p> <p>Fee: \$1,886.15 Benefit: 75% = \$1,414.65</p>
38721	<p>VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)</p> <p>Fee: \$1,321.70 Benefit: 75% = \$991.30</p>
38724	<p>VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)</p> <p>Fee: \$1,886.15 Benefit: 75% = \$1,414.65</p>

OPERATIONS	NEUROSURGICAL
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: \$1,321.70 Benefit: 75% = \$991.30
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: \$1,886.15 Benefit: 75% = \$1,414.65
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,321.70 Benefit: 75% = \$991.30
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,886.15 Benefit: 75% = \$1,414.65
38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,700.20 Benefit: 75% = \$1,275.15
38742	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,700.20 Benefit: 75% = \$1,275.15
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,886.15 Benefit: 75% = \$1,414.65
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,886.15 Benefit: 75% = \$1,414.65
38751	VENTRICULAR SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,886.15 Benefit: 75% = \$1,414.65
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) Fee: \$2,361.05 Benefit: 75% = \$1,770.80
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,886.15 Benefit: 75% = \$1,414.65
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,886.15 Benefit: 75% = \$1,414.65
38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,886.15 Benefit: 75% = \$1,414.65
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,886.15 Benefit: 75% = \$1,414.65
	MISCELLANEOUS PROCEDURES ON THE CHEST
38800	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies Fee: \$34.05 Benefit: 75% = \$25.55 85% = \$28.95
38803	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample Fee: \$67.90 Benefit: 75% = \$50.95 85% = \$57.75
38806	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.) Fee: \$118.05 Benefit: 75% = \$88.55 85% = \$100.35
38809	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.) Fee: \$145.45 Benefit: 75% = \$109.10 85% = \$123.65
38812	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) Fee: \$184.85 Benefit: 75% = \$138.65 85% = \$157.15

OPERATIONS	NEUROSURGICAL
SUBGROUP 7 - NEUROSURGICAL	
GENERAL	
39000	LUMBAR PUNCTURE (Anaes.) Fee: \$66.55 Benefit: 75% = \$49.95 85% = \$56.60
39003	CISTERNAL PUNCTURE (Anaes.) Fee: \$75.70 Benefit: 75% = \$56.80 85% = \$64.35
39006	VENTRICULAR PUNCTURE (not including burr-hole) (Anaes.) Fee: \$140.90 Benefit: 75% = \$105.70 85% = \$119.80
39009	SUBDURAL HAEMORRHAGE, tap for, each tap (Anaes.) Fee: \$52.45 Benefit: 75% = \$39.35
39012	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.) Fee: \$209.95 Benefit: 75% = \$157.50
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: \$96.50 Benefit: 75% = \$72.40 85% = \$82.05
39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.) (Assist.) Fee: \$332.25 Benefit: 75% = \$249.20
39018	CEREBROSPINAL FLUID reservoir, insertion of (Anaes.) (Assist.) Fee: \$332.25 Benefit: 75% = \$249.20
PROCEDURES FOR PAIN RELIEF	
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) Fee: \$209.95 Benefit: 75% = \$157.50 85% = \$178.50
39106	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.) Fee: \$1,049.95 Benefit: 75% = \$787.50
39109	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.) Fee: \$392.05 Benefit: 75% = \$294.05 85% = \$333.25
39112	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$1,362.20 Benefit: 75% = \$1,021.65
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: \$66.55 Benefit: 75% = \$49.95 85% = \$56.60
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.) Fee: \$263.15 Benefit: 75% = \$197.40 85% = \$223.70
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) Fee: \$558.25 Benefit: 75% = \$418.70 85% = \$494.35
‡ 39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) Fee: \$1,428.65 Benefit: 75% = \$1,071.50
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: \$263.35 Benefit: 75% = \$197.55

OPERATIONS	NEUROSURGICAL
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: \$319.80 Benefit: 75% = \$239.85
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic intractable pain (Anaes.) Fee: \$418.55 Benefit: 75% = \$313.95
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: \$583.15 Benefit: 75% = \$437.40
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: \$595.75 Benefit: 75% = \$446.85
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: \$112.95 Benefit: 75% = \$84.75 85% = \$96.05
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: \$140.90 Benefit: 75% = \$105.70
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: \$301.00 Benefit: 75% = \$225.75
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: \$140.90 Benefit: 75% = \$105.70 85% = \$119.80
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: \$140.90 Benefit: 75% = \$105.70
39137	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or 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: \$534.95 Benefit: 75% = \$401.25
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: \$595.75 Benefit: 75% = \$446.85
‡ 39139	EPIDURAL LEAD, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.) Fee: \$799.75 Benefit: 75% = \$599.85
39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) Fee: \$258.75 Benefit: 75% = \$194.10 85% = \$219.95
PERIPHERAL NERVES	
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$312.25 Benefit: 75% = \$234.20
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$411.85 Benefit: 75% = \$308.90

OPERATIONS	NEUROSURGICAL
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$598.10 Benefit: 75% = \$448.60
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$631.20 Benefit: 75% = \$473.40
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$352.15 Benefit: 75% = \$264.15
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) Fee: \$910.30 Benefit: 75% = \$682.75
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.) Fee: \$564.80 Benefit: 75% = \$423.60
39321	NERVE, transposition of (Anaes.) (Assist.) Fee: \$418.55 Benefit: 75% = \$313.95
39323	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.) Fee: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.) Fee: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90
‡ 39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral or cranial nerve, by open operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.) Fee: \$418.55 Benefit: 75% = \$313.95
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.) Fee: \$244.55 Benefit: 75% = \$183.45
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.) Fee: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$352.15 Benefit: 75% = \$264.15 85% = \$299.35
CRANIAL NERVES	
39500	VESTIBULAR NERVE, section of, via posterior fossa (Anaes.) (Assist.) Fee: \$1,123.05 Benefit: 75% = \$842.30
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.) Fee: \$843.85 Benefit: 75% = \$632.90
CRANIO-CEREBRAL INJURIES	
39600	INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes (Anaes.) (Assist.) Fee: \$418.55 Benefit: 75% = \$313.95
39603	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes.) (Assist.) Fee: \$1,056.55 Benefit: 75% = \$792.45
39606	FRACTURED SKULL, depressed or comminuted, operation for (Anaes.) (Assist.) Fee: \$704.35 Benefit: 75% = \$528.30
39609	FRACTURED SKULL, compound, without dural penetration, operation for (Anaes.) (Assist.) Fee: \$843.85 Benefit: 75% = \$632.90
39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.) (Assist.) Fee: \$990.10 Benefit: 75% = \$742.60

OPERATIONS	NEUROSURGICAL
39615	FRACTURED SKULL with rhinorrhoea or otorrhoea, cranioplasty and repair of (Anaes.) (Assist.) Fee: \$1,056.55 Benefit: 75% = \$792.45
SKULL BASE SURGERY	
39640	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$2,678.90 Benefit: 75% = \$2,009.20
39642	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$2,816.40 Benefit: 75% = \$2,112.30
39646	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$3,228.45 Benefit: 75% = \$2,421.35
39650	TUMOUR INVOLVING MIDDLE CRANIAL FOSSA AND INFRA-TEMPORAL FOSSA, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$2,335.40 Benefit: 75% = \$1,751.55
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.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$4,155.85 Benefit: 75% = \$3,116.90
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.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$3,022.45 Benefit: 75% = \$2,266.85
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.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$2,266.80 Benefit: 75% = \$1,700.10
39658	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$2,678.90 Benefit: 75% = \$2,009.20
39660	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$2,678.90 Benefit: 75% = \$2,009.20
39662	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$2,678.90 Benefit: 75% = \$2,009.20
INTRACRANIAL NEOPLASMS	
39700	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes.) (Assist.) Fee: \$491.85 Benefit: 75% = \$368.90
39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes.) (Assist.) Fee: \$458.50 Benefit: 75% = \$343.90

OPERATIONS	NEUROSURGICAL
39706	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes.) (Assist.) Fee: \$983.35 Benefit: 75% = \$737.55
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: \$1,402.10 Benefit: 75% = \$1,051.60
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: \$2,531.60 Benefit: 75% = \$1,898.70
39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (Anaes.) (Assist.) Fee: \$1,754.30 Benefit: 75% = \$1,315.75
39718	ARACHNOIDAL CYST, craniotomy for (Anaes.) (Assist.) Fee: \$770.80 Benefit: 75% = \$578.10
39721	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes.) (Assist.) Fee: \$704.35 Benefit: 75% = \$528.30
CEREBROVASCULAR DISEASE	
39800	ANEURYSM, clipping or reinforcement of sac (Anaes.) (Assist.) Fee: \$2,525.05 Benefit: 75% = \$1,893.80
39803	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.) Fee: \$2,525.05 Benefit: 75% = \$1,893.80
39806	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.) Fee: \$1,136.20 Benefit: 75% = \$852.15
39812	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.) (Assist.) Fee: \$558.25 Benefit: 75% = \$418.70
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.) Fee: \$1,614.65 Benefit: 75% = \$1,211.00 85% = \$1,550.75
39818	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.) Fee: \$1,614.65 Benefit: 75% = \$1,211.00
39821	EXTRACRANIAL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.) Fee: \$1,917.30 Benefit: 75% = \$1,438.00
INFECTION	
39900	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.) Fee: \$458.50 Benefit: 75% = \$343.90
39903	INTRACRANIAL ABSCESS, excision of (Anaes.) (Assist.) Fee: \$1,402.10 Benefit: 75% = \$1,051.60
39906	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.) Fee: \$704.35 Benefit: 75% = \$528.30
CEREBRO-SPINAL FLUID CIRCULATION DISORDERS	
40000	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.) Fee: \$810.65 Benefit: 75% = \$608.00
40003	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.) Fee: \$810.65 Benefit: 75% = \$608.00
40006	LUMBAR SHUNT DIVERSION, insertion of (Anaes.) (Assist.) Fee: \$637.90 Benefit: 75% = \$478.45

OPERATIONS	NEUROSURGICAL
40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.) Fee: \$465.10 Benefit: 75% = \$348.85
40012	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.) (Assist.) Fee: \$910.30 Benefit: 75% = \$682.75
40015	SUBTEMPORAL DECOMPRESSION (Anaes.) (Assist.) Fee: \$564.40 Benefit: 75% = \$423.30
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.) Fee: \$140.90 Benefit: 75% = \$105.70 85% = \$119.80
	CONGENITAL DISORDERS
40100	MENINGOCELE, excision and closure of (Anaes.) (Assist.) Fee: \$611.30 Benefit: 75% = \$458.50
40103	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (Anaes.) (Assist.) Fee: \$897.10 Benefit: 75% = \$672.85
40106	ARNOLD-CHIARI MALFORMATION, decompression of (Anaes.) (Assist.) Fee: \$910.30 Benefit: 75% = \$682.75
40109	ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.) Fee: \$983.35 Benefit: 75% = \$737.55
40112	TETHERED CORD, release of, including lipomenigocele or diastematomyelia (Anaes.) (Assist.) Fee: \$1,262.50 Benefit: 75% = \$946.90
40115	CRANIOSTENOSIS, operation for - single suture (Anaes.) (Assist.) Fee: \$637.90 Benefit: 75% = \$478.45
40118	CRANIOSTENOSIS, operation for - more than 1 suture (Anaes.) (Assist.) Fee: \$843.85 Benefit: 75% = \$632.90
	SPINAL DISORDERS
‡ 40300	INTERVERTEBRAL DISC OR DISCS, partial or total laminectomy for removal of (Anaes.) (Assist.) Fee: \$843.85 Benefit: 75% = \$632.90
‡ 40301	INTERVERTEBRAL DISC OR DISCS, microsurgical partial or total discectomy of (Anaes.) (Assist.) Fee: \$846.55 Benefit: 75% = \$634.95
‡ 40303	RECURRENT DISC LESION OR SPINAL STENOSIS, or both, partial or total laminectomy for - 1 level (Anaes.) (Assist.) Fee: \$963.45 Benefit: 75% = \$722.60
‡ 40306	SPINAL STENOSIS, partial or total laminectomy for, involving more than 1 vertebral interspace (disc level) (Anaes.) (Assist.) Fee: \$1,269.15 Benefit: 75% = \$951.90
‡ 40309	EEXTRADURAL TUMOUR OR ABSCESS, partial or total laminectomy for (Anaes.) (Assist.) Fee: \$963.45 Benefit: 75% = \$722.60
‡ 40312	INTRADURAL LESION, partial or total laminectomy for, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$1,295.70 Benefit: 75% = \$971.80
40315	CRANIOCERVICAL JUNCTION LESION, transoral approach for (Anaes.) (Assist.) Fee: \$1,402.10 Benefit: 75% = \$1,051.60
40316	ODONTOID screw fixation (Anaes.) (Assist.) Fee: \$1,837.70 Benefit: 75% = \$1,378.30
‡ 40318	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, partial or total laminectomy and radical excision of (Anaes.) (Assist.) Fee: \$1,754.30 Benefit: 75% = \$1,315.75

OPERATIONS	NEUROSURGICAL
40321	POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (Anaes.) (Assist.) Fee: \$963.45 Benefit: 75% = \$722.60
‡ 40324	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – laminectomy, including aftercare (Anaes.) (Assist.) Fee: \$564.80 Benefit: 75% = \$423.60
‡ 40327	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – posterior fusion, including aftercare (Assist.) Fee: \$564.80 Benefit: 75% = \$423.60
‡ 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 partial or total laminectomy (Anaes.) (Assist.) Fee: \$843.85 Benefit: 75% = \$632.90
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: \$843.85 Benefit: 75% = \$632.90
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: \$1,377.00 Benefit: 75% = \$1,032.75
‡ 40333	CERVICAL PARTIAL OR TOTAL DISCECTOMY (ANTERIOR), without fusion (Anaes.) (Assist.) Fee: \$704.35 Benefit: 75% = \$528.30
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: \$931.20 Benefit: 75% = \$698.40
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: \$1,710.30 Benefit: 75% = \$1,282.75
40336	INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCASE) - 1 disc (Anaes.) (Assist.) <i>(See para T8.72 of explanatory notes to this Category)</i> Fee: \$279.15 Benefit: 75% = \$209.40
40339	HYDROMYELIA, plugging of obex for, with or without duroplasty (Anaes.) (Assist.) Fee: \$1,402.10 Benefit: 75% = \$1,051.60
‡ 40342	HYDROMYELIA, craniotomy and partial or total laminectomy for, with cavity packing and CSF shunt (Anaes.) (Assist.) Fee: \$1,295.70 Benefit: 75% = \$971.80
40345	THORACIC DECOMPRESSION of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Anaes.) (Assist.) Fee: \$1,206.20 Benefit: 75% = \$904.65
40348	THORACIC DECOMPRESSION of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes.) (Assist.) Fee: \$1,531.40 Benefit: 75% = \$1,148.55
40351	THORACO-LUMBAR or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Anaes.) (Assist.) Fee: \$1,531.40 Benefit: 75% = \$1,148.55
SKULL RECONSTRUCTION	
40600	CRANIOPLASTY, reconstructive (Anaes.) (Assist.) Fee: \$843.85 Benefit: 75% = \$632.90
EPILEPSY	
40700	CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes.) (Assist.) Fee: \$1,541.65 Benefit: 75% = \$1,156.25

OPERATIONS	NEUROSURGICAL
40703	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.) Fee: \$1,295.70 Benefit: 75% = \$971.80
40706	HEMISPHERECTOMY for intractable epilepsy (Anaes.) (Assist.) Fee: \$1,893.75 Benefit: 75% = \$1,420.35 85% = \$1,829.85
40709	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes.) (Assist.) Fee: \$458.50 Benefit: 75% = \$343.90
40712	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes.) (Assist.) Fee: \$923.60 Benefit: 75% = \$692.70
	STEREOTACTIC PROCEDURES ON THE HEAD
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes.) (Assist.) Fee: \$564.40 Benefit: 75% = \$423.30 85% = \$500.50
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: \$1,542.65 Benefit: 75% = \$1,157.00
40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes.) (Assist.) Fee: \$1,056.55 Benefit: 75% = \$792.45 85% = \$992.65
† 40850	DEEP BRAIN STIMULATION (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes (Anaes.) (Assist.) Fee: \$2,001.05 Benefit: 75% = \$1,500.80
† 40851	DEEP BRAIN STIMULATION (bilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes (Anaes.) (Assist.) Fee: \$3,501.90 Benefit: 75% = \$2,626.45
† 40852	DEEP BRAIN STIMULATION (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, subcutaneous placement of neurostimulator receiver or pulse generator (Anaes.) (Assist.) Fee: \$301.00 Benefit: 75% = \$225.75
† 40854	DEEP BRAIN STIMULATION (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, revision or removal of brain electrode (Anaes.) Fee: \$465.10 Benefit: 75% = \$348.85
† 40856	DEEP BRAIN STIMULATION (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, removal or replacement of neurostimulator receiver or pulse generator (Anaes.) Fee: \$225.75 Benefit: 75% = \$169.35
† 40858	DEEP BRAIN STIMULATION (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, placement, removal or replacement of extension lead (Anaes.) Fee: \$465.10 Benefit: 75% = \$348.85
† 40860	DEEP BRAIN STIMULATION (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire (Anaes.) Fee: \$1,787.40 Benefit: 75% = \$1,340.55
† 40862	DEEP BRAIN STIMULATION (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, electronic analysis and programming of neurostimulator pulse generator (Anaes.) Fee: \$167.55 Benefit: 75% = \$125.70 85% = \$142.45

OPERATIONS		EAR, NOSE AND THROAT
MISCELLANEOUS		
40903	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.) Fee: \$490.00 Benefit: 75% = \$367.50	
40905	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.) Fee: \$531.65 Benefit: 75% = \$398.75 85% = \$467.75	
SUBGROUP 8 - EAR, NOSE AND THROAT		
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) <i>(See para T8.73 of explanatory notes to this Category)</i> Fee: \$72.90 Benefit: 75% = \$54.70 85% = \$62.00	
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.) Fee: \$211.05 Benefit: 75% = \$158.30 85% = \$179.40	
41506	AURAL POLYP, removal of (Anaes.) Fee: \$127.25 Benefit: 75% = \$95.45 85% = \$108.20	
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.) Fee: \$144.00 Benefit: 75% = \$108.00 85% = \$122.40	
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: \$517.80 Benefit: 75% = \$388.35	
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.) <i>(See para T8.74 of explanatory notes to this Category)</i> Fee: \$339.80 Benefit: 75% = \$254.85	
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) Fee: \$820.70 Benefit: 75% = \$615.55	
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.) Fee: \$873.80 Benefit: 75% = \$655.35	
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.) <i>(See para T8.75 of explanatory notes to this Category)</i> Fee: \$252.45 Benefit: 75% = \$189.35	
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45	
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.) Fee: \$845.90 Benefit: 75% = \$634.45	
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) Fee: \$1,011.20 Benefit: 75% = \$758.40	
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) Fee: \$1,132.60 Benefit: 75% = \$849.45	
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) Fee: \$963.10 Benefit: 75% = \$722.35	
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.) Fee: \$1,055.30 Benefit: 75% = \$791.50	
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45	

OPERATIONS		EAR, NOSE AND THROAT
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) Fee: \$611.30 Benefit: 75% = \$458.50	
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.) Fee: \$1,407.70 Benefit: 75% = \$1,055.80	
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.) Fee: \$1,658.50 Benefit: 75% = \$1,243.90	
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.) Fee: \$963.10 Benefit: 75% = \$722.35	
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.) Fee: \$1,055.30 Benefit: 75% = \$791.50	
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) Fee: \$1,306.40 Benefit: 75% = \$979.80	
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: \$1,689.40 Benefit: 75% = \$1,267.05	
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.) Fee: \$963.10 Benefit: 75% = \$722.35	
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.) Fee: \$1,055.30 Benefit: 75% = \$791.50	
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) Fee: \$912.95 Benefit: 75% = \$684.75	
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: \$2,152.30 Benefit: 75% = \$1,614.25	
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: \$3,228.45 Benefit: 75% = \$2,421.35	
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$2,152.30 Benefit: 75% = \$1,614.25	
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) Fee: \$1,614.20 Benefit: 75% = \$1,210.65	
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) Fee: \$2,475.55 Benefit: 75% = \$1,856.70	
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) Fee: \$1,698.90 Benefit: 75% = \$1,274.20	
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) Fee: \$2,313.85 Benefit: 75% = \$1,735.40	
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) Fee: \$1,055.30 Benefit: 75% = \$791.50	
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) Fee: \$1,375.40 Benefit: 75% = \$1,031.55	
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) Fee: \$1,537.10 Benefit: 75% = \$1,152.85	

OPERATIONS	EAR, NOSE AND THROAT
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) Fee: \$1,537.10 Benefit: 75% = \$1,152.85
† 41603	OSSEO-INTEGRATION PROCEDURE – implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) Fee: \$445.25 Benefit: 75% = \$333.95 85% = \$381.35
† 41604	OSSEO-INTEGRATION PROCEDURE – fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) Fee: \$164.80 Benefit: 75% = \$123.60 85% = \$140.10
41608	STAPEDECTOMY (Anaes.) (Assist.) Fee: \$963.10 Benefit: 75% = \$722.35
41611	STAPES MOBILISATION (Anaes.) (Assist.) Fee: \$619.65 Benefit: 75% = \$464.75
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.) Fee: \$963.10 Benefit: 75% = \$722.35 85% = \$899.20
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: \$963.10 Benefit: 75% = \$722.35 85% = \$899.20
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.) Fee: \$1,674.70 Benefit: 75% = \$1,256.05
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) Fee: \$728.60 Benefit: 75% = \$546.45
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) Fee: \$1,055.30 Benefit: 75% = \$791.50
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.) Fee: \$127.25 Benefit: 75% = \$95.45 85% = \$108.20
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.) Fee: \$211.05 Benefit: 75% = \$158.30 85% = \$179.40
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.) Fee: \$1,011.20 Benefit: 75% = \$758.40 85% = \$947.30
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.) Fee: \$1,262.15 Benefit: 75% = \$946.65
41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) Fee: \$41.95 Benefit: 75% = \$31.50 85% = \$35.70
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) Fee: \$126.15 Benefit: 75% = \$94.65 85% = \$107.25

OPERATIONS		EAR, NOSE AND THROAT	
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.) Fee: \$97.10	Benefit: 75% = \$72.85	85% = \$82.55
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: \$97.10	Benefit: 75% = \$72.85	85% = \$82.55
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: \$63.55	Benefit: 75% = \$47.70	85% = \$54.05
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) Fee: \$108.55	Benefit: 75% = \$81.45	85% = \$92.30
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) Fee: \$68.55	Benefit: 75% = \$51.45	85% = \$58.30
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of (See para T8.76 of explanatory notes to this Category) Fee: \$72.90	Benefit: 75% = \$54.70	85% = \$62.00
41665 G 41668 S	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes.) (See para T8.76 of explanatory notes to this Category) Fee: \$152.45 Fee: \$194.35	Benefit: 75% = \$114.35 Benefit: 75% = \$145.80	
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.) Fee: \$427.05	Benefit: 75% = \$320.30	
41672	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) Fee: \$532.75	Benefit: 75% = \$399.60	
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: \$88.80	Benefit: 75% = \$66.60	85% = \$75.50
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) Fee: \$79.50	Benefit: 75% = \$59.65	85% = \$67.60
41680	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) Fee: \$144.00	Benefit: 75% = \$108.00	85% = \$122.40
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: \$103.50	Benefit: 75% = \$77.65	85% = \$88.00
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: \$63.55	Benefit: 75% = \$47.70	85% = \$54.05
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.) Fee: \$120.60	Benefit: 75% = \$90.45	
41692	TURBINATES, submucous resection of, unilateral (Anaes.) Fee: \$157.30	Benefit: 75% = \$118.00	
41695	TURBINATES, cryotherapy to (Anaes.) Fee: \$88.35	Benefit: 75% = \$66.30	85% = \$75.10
41698	MAXILLARY ANTRUM, PNEUMATIC PUNCTURE AND LAVAGE OF (Anaes.) Fee: \$28.70	Benefit: 75% = \$21.55	85% = \$24.40

OPERATIONS	EAR, NOSE AND THROAT
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: \$81.25 Benefit: 75% = \$60.95
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) Fee: \$32.10 Benefit: 75% = \$24.10 85% = \$27.30
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.) Fee: \$396.35 Benefit: 75% = \$297.30
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.) Fee: \$535.95 Benefit: 75% = \$402.00
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95
41719	ANTRUM, drainage of, through tooth socket (Anaes.) Fee: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30
41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45 85% = \$455.35
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.) Fee: \$396.35 Benefit: 75% = \$297.30
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.) Fee: \$792.90 Benefit: 75% = \$594.70
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.) Fee: \$502.50 Benefit: 75% = \$376.90
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.) Fee: \$686.70 Benefit: 75% = \$515.05
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.) Fee: \$896.10 Benefit: 75% = \$672.10
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.) Fee: \$427.05 Benefit: 75% = \$320.30
41740	FRONTAL SINUS, catheterisation of (Anaes.) Fee: \$51.95 Benefit: 75% = \$39.00
41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.) Fee: \$298.20 Benefit: 75% = \$223.65
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.) Fee: \$686.70 Benefit: 75% = \$515.05 85% = \$622.80
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.) Fee: \$535.95 Benefit: 75% = \$402.00
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) Fee: \$41.10 Benefit: 75% = \$30.85 85% = \$34.95
41758	DIVISION OF PHARYNGEAL ADHESIONS (Anaes.) Fee: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30
41761	POSTNASAL SPACE, direct examination of, with or without biopsy (Anaes.) Fee: \$108.55 Benefit: 75% = \$81.45 85% = \$92.30

OPERATIONS		EAR, NOSE AND THROAT	
‡ 41764	NASENDOSCOPY or SINOSCOPY or FIBROPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures, unilateral or bilateral examination (Anaes.) Fee: \$108.55 Benefit: 75% = \$81.45 85% = \$92.30		
41767	NASOPHARYNGEAL ANGIOFIBROMA, transpalatal removal (Anaes.) (Assist.) Fee: \$651.20 Benefit: 75% = \$488.40 85% = \$587.30		
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) Fee: \$619.65 Benefit: 75% = \$464.75		
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohman's operation) (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45		
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.) Fee: \$517.80 Benefit: 75% = \$388.35		
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) Fee: \$619.65 Benefit: 75% = \$464.75		
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.) Fee: \$841.30 Benefit: 75% = \$631.00 85% = \$777.40		
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.) Fee: \$1,043.70 Benefit: 75% = \$782.80		
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) Fee: \$651.20 Benefit: 75% = \$488.40		
41787	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.) Fee: \$502.50 Benefit: 75% = \$376.90 85% = \$438.60		
41788 G 41789 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes.) Fee: \$194.35 Benefit: 75% = \$145.80 Fee: \$261.25 Benefit: 75% = \$195.95		
41792 G 41793 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes.) Fee: \$244.55 Benefit: 75% = \$183.45 Fee: \$328.30 Benefit: 75% = \$246.25		
41796 G 41797 S	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) Fee: \$100.50 Benefit: 75% = \$75.40 Fee: \$127.25 Benefit: 75% = \$95.45		
41800 G 41801 S	ADENOIDS, removal of (Anaes.) Fee: \$103.85 Benefit: 75% = \$77.90 Fee: \$144.00 Benefit: 75% = \$108.00		
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.) Fee: \$79.50 Benefit: 75% = \$59.65		
41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) Fee: \$61.95 Benefit: 75% = \$46.50 85% = \$52.70		
41810	UVULOTOMY or UVULECTOMY (Anaes.) Fee: \$31.45 Benefit: 75% = \$23.60 85% = \$26.75		
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20		
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.) Fee: \$164.05 Benefit: 75% = \$123.05 85% = \$139.45		
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: \$308.35 Benefit: 75% = \$231.30 85% = \$262.10		

OPERATIONS	EAR, NOSE AND THROAT
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: \$370.05 Benefit: 75% = \$277.55 85% = \$314.55
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.) Fee: \$211.05 Benefit: 75% = \$158.30
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) Fee: \$46.15 Benefit: 75% = \$34.65 85% = \$39.25
41831	OESOPHAGUS, endoscopic pneumatic dilatation of (Anaes.) (Assist.) Fee: \$315.50 Benefit: 75% = \$236.65 85% = \$268.20
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) Fee: \$201.90 Benefit: 75% = \$151.45 85% = \$171.65
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.) Fee: \$1,139.10 Benefit: 75% = \$854.35
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.) Fee: \$1,092.20 Benefit: 75% = \$819.15
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.) Fee: \$1,342.95 Benefit: 75% = \$1,007.25
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) Fee: \$1,180.95 Benefit: 75% = \$885.75
41846	LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes.) <i>(See para T8.77 of explanatory notes to this Category)</i> Fee: \$164.05 Benefit: 75% = \$123.05 85% = \$139.45
41849	LARYNX, direct examination of, with biopsy (Anaes.) (Assist.) Fee: \$241.15 Benefit: 75% = \$180.90
41852	LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95
41855	MICROLARYNGOSCOPY (Anaes.) (Assist.) Fee: \$254.70 Benefit: 75% = \$191.05
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.) <i>(See para T8.78 of explanatory notes to this Category)</i> Fee: \$436.70 Benefit: 75% = \$327.55
41861	MICROLARYNGOSCOPY with removal of papillomata by laser surgery (Anaes.) (Assist.) Fee: \$533.95 Benefit: 75% = \$400.50
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) Fee: \$360.10 Benefit: 75% = \$270.10
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.) Fee: \$542.00 Benefit: 75% = \$406.50
41868	LARYNGEAL WEB, division of, using microlarygoscopic techniques (Anaes.) Fee: \$343.50 Benefit: 75% = \$257.65
41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.) Fee: \$401.90 Benefit: 75% = \$301.45

OPERATIONS		OPHTHALMOLOGY	
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45 85% = \$455.35		
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45 85% = \$455.35		
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.) Fee: \$841.30 Benefit: 75% = \$631.00		
41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.) Fee: \$224.55 Benefit: 75% = \$168.45		
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: \$354.95 Benefit: 75% = \$266.25		
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) Fee: \$80.45 Benefit: 75% = \$60.35		
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) Fee: \$254.40 Benefit: 75% = \$190.80 85% = \$216.25		
41886	TRACHEA, removal of foreign body in (Anaes.) Fee: \$157.30 Benefit: 75% = \$118.00 85% = \$133.75		
41889	BRONCHOSCOPY, as an independent procedure (Anaes.) Fee: \$157.30 Benefit: 75% = \$118.00 85% = \$133.75		
41892	BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) Fee: \$207.70 Benefit: 75% = \$155.80 85% = \$176.55		
41895	BRONCHUS, removal of foreign body in (Anaes.) (Assist.) Fee: \$324.95 Benefit: 75% = \$243.75		
41898	FIBROPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.) Fee: \$227.05 Benefit: 75% = \$170.30 85% = \$193.00		
41901	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.) Fee: \$533.95 Benefit: 75% = \$400.50		
41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.) Fee: \$217.80 Benefit: 75% = \$163.35 85% = \$185.15		
41905	TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) Fee: \$400.65 Benefit: 75% = \$300.50		
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) Fee: \$108.55 Benefit: 75% = \$81.45 85% = \$92.30		
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) Fee: \$344.80 Benefit: 75% = \$258.60		
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: \$90.55 Benefit: 75% = \$67.95		
42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) Fee: \$425.25 Benefit: 75% = \$318.95 85% = \$361.50		
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) Fee: \$538.20 Benefit: 75% = \$403.65		

OPERATIONS	OPHTHALMOLOGY
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) Fee: \$620.35 Benefit: 75% = \$465.30
42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.) Fee: \$425.25 Benefit: 75% = \$318.95 85% = \$361.50
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) Fee: \$538.20 Benefit: 75% = \$403.65
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: \$312.25 Benefit: 75% = \$234.20
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) Fee: \$1,063.20 Benefit: 75% = \$797.40
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.) Fee: \$180.75 Benefit: 75% = \$135.60 85% = \$153.65
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) Fee: \$558.25 Benefit: 75% = \$418.70
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) Fee: \$737.50 Benefit: 75% = \$553.15
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) Fee: \$1,049.95 Benefit: 75% = \$787.50
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) Fee: \$445.25 Benefit: 75% = \$333.95
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) Fee: \$780.95 Benefit: 75% = \$585.75
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: \$1,129.60 Benefit: 75% = \$847.20
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) Fee: \$671.10 Benefit: 75% = \$503.35
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: \$558.25 Benefit: 75% = \$418.70 85% = \$494.35
42554	EYEBALL, PERFORATING WOUND OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) Fee: \$651.20 Benefit: 75% = \$488.40
42557	EYEBALL, PERFORATING WOUND OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) Fee: \$910.30 Benefit: 75% = \$682.75
42560	INTRAOCULAR FOREIGN BODY, magnetic removal from anterior segment (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00
42563	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from anterior segment (Anaes.) (Assist.) Fee: \$458.50 Benefit: 75% = \$343.90 85% = \$394.60

OPERATIONS		OPHTHALMOLOGY	
42566	INTRAOCULAR FOREIGN BODY, magnetic removal from posterior segment (Anaes.) (Assist.) Fee: \$651.20 Benefit: 75% = \$488.40		
42569	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from posterior segment (Anaes.) (Assist.) Fee: \$910.30 Benefit: 75% = \$682.75		
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) Fee: \$103.65 Benefit: 75% = \$77.75 85% = \$88.15		
42573	DERMOID, periorbital, excision of (Anaes.) Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85		
42574	DERMOID, orbital, excision of (Anaes.) (Assist.) Fee: \$427.05 Benefit: 75% = \$320.30 85% = \$363.15		
42575	TARSAL CYST, extirpation of (Anaes.) Fee: \$73.15 Benefit: 75% = \$54.90 85% = \$62.20		
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) Fee: \$103.65 Benefit: 75% = \$77.75 85% = \$88.15		
42584	TARSORRHAPHY (Anaes.) (Assist.) Fee: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90		
42587	TRICHIASIS, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) Fee: \$45.90 Benefit: 75% = \$34.45 85% = \$39.05		
42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) Fee: \$298.95 Benefit: 75% = \$224.25 85% = \$254.15		
42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes.) Fee: \$180.75 Benefit: 75% = \$135.60		
42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) Fee: \$445.25 Benefit: 75% = \$333.95 85% = \$381.35		
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.) Fee: \$558.25 Benefit: 75% = \$418.70 85% = \$494.35		
42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) Fee: \$558.25 Benefit: 75% = \$418.70 85% = \$494.35		
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) Fee: \$411.85 Benefit: 75% = \$308.90 85% = \$350.10		
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) Fee: \$265.75 Benefit: 75% = \$199.35 85% = \$225.90		
42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) Fee: \$85.05 Benefit: 75% = \$63.80 85% = \$72.30		
42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) Fee: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45		
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: \$42.65 Benefit: 75% = \$32.00 85% = \$36.30		
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: \$63.80 Benefit: 75% = \$47.85 85% = \$54.25		

OPERATIONS		OPHTHALMOLOGY	
42617	PUNCTUM SNIP operation (Anaes.) Fee: \$121.00 Benefit: 75% = \$90.75 85% = \$102.85		
42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) Fee: \$46.55 Benefit: 75% = \$34.95 85% = \$39.60		
42621	PUNCTUM, temporary occlusion of, by use of electrical cautery (Anaes.) Fee: \$46.55 Benefit: 75% = \$34.95 85% = \$39.60		
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) Fee: \$73.15 Benefit: 75% = \$54.90 85% = \$62.20		
42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) Fee: \$618.05 Benefit: 75% = \$463.55		
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.) Fee: \$996.75 Benefit: 75% = \$747.60 85% = \$932.85		
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.) Fee: \$750.85 Benefit: 75% = \$563.15		
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) Fee: \$103.65 Benefit: 75% = \$77.75 85% = \$88.15		
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) Fee: \$265.75 Benefit: 75% = \$199.35 85% = \$225.90		
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) Fee: \$332.25 Benefit: 75% = \$249.20 85% = \$282.45		
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) Fee: \$431.90 Benefit: 75% = \$323.95 85% = \$368.00		
42644	CORNEA OR SCLERA, removal of imbedded foreign body from (excluding aftercare) (Anaes.) <i>(See para T8.79 of explanatory notes to this Category)</i> Fee: \$63.70 Benefit: 75% = \$47.80 85% = \$54.15		
42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) Fee: \$180.75 Benefit: 75% = \$135.60 85% = \$153.65		
42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.) Fee: \$63.70 Benefit: 75% = \$47.80 85% = \$54.15		
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) Fee: \$142.05 Benefit: 75% = \$106.55 85% = \$120.75		
42653	CORNEA, transplantation of, full thickness (Anaes.) (Assist.) Fee: \$1,182.75 Benefit: 75% = \$887.10		
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) Fee: \$1,475.20 Benefit: 75% = \$1,106.40		
42659	CORNEA, transplantation of, superficial or lamellar (Anaes.) (Assist.) Fee: \$797.35 Benefit: 75% = \$598.05 85% = \$733.45		
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) Fee: \$797.35 Benefit: 75% = \$598.05		
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.) Fee: \$531.60 Benefit: 75% = \$398.70 85% = \$467.70		
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: \$125.45 Benefit: 75% = \$94.10 85% = \$106.65		

OPERATIONS		OPHTHALMOLOGY	
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) Fee: \$66.55	Benefit: 75% = \$49.95	85% = \$56.60
42672	CORNEAL INCISIONS, to correct corneal astigmatism of more than 1½ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.) <i>(See para T8.80 of explanatory notes to this Category)</i> Fee: \$797.35	Benefit: 75% = \$598.05	85% = \$733.45
42673	ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than 1½ dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.) Fee: \$398.65	Benefit: 75% = \$299.00	85% = \$338.90
42676	CONJUNCTIVA, biopsy of, as an independent procedure Fee: \$102.25	Benefit: 75% = \$76.70	85% = \$86.95
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) Fee: \$53.85	Benefit: 75% = \$40.40	85% = \$45.80
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO ² or N ² O (Anaes.) Fee: \$265.75	Benefit: 75% = \$199.35	85% = \$225.90
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) Fee: \$106.35	Benefit: 75% = \$79.80	
42686	PTERYGIUM, removal of (Anaes.) Fee: \$241.85	Benefit: 75% = \$181.40	85% = \$205.60
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) Fee: \$103.65	Benefit: 75% = \$77.75	85% = \$88.15
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) Fee: \$244.55	Benefit: 75% = \$183.45	85% = \$207.90
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) Fee: \$398.65	Benefit: 75% = \$299.00	85% = \$338.90
42698	LENS EXTRACTION, excluding surgery performed for the correction of refractive error <i>except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye</i> (Anaes.) Fee: \$621.95	Benefit: 75% = \$466.50	85% = \$558.05
42701	ARTIFICIAL LENS, insertion of, excluding surgery performed for the correction of refractive error <i>except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye</i> (Anaes.) Fee: \$346.80	Benefit: 75% = \$260.10	85% = \$294.80
42702	LENS EXTRACTION AND INSERTION OF ARTIFICIAL LENS, excluding surgery performed for the correction of refractive error <i>except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye</i> (Anaes.) Fee: \$795.40	Benefit: 75% = \$596.55	85% = \$731.50
42703	ARTIFICIAL LENS, insertion of, into the posterior chamber and suture to the iris and sclera (Anaes.) (Assist.) Fee: \$505.50	Benefit: 75% = \$379.15	85% = \$441.60
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: \$411.85	Benefit: 75% = \$308.90	85% = \$350.10
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: \$704.35	Benefit: 75% = \$528.30	85% = \$640.45
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: \$797.35	Benefit: 75% = \$598.05	85% = \$733.45

OPERATIONS	OPHTHALMOLOGY
42713	INTRAOCULAR LENSES, repositioning of, by the use of a McCannell suture or similar (Anaes.) (Assist.) Fee: \$332.25 Benefit: 75% = \$249.20 85% = \$282.45
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) Fee: \$1,056.55 Benefit: 75% = \$792.45 85% = \$992.65
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: \$458.50 Benefit: 75% = \$343.90 85% = \$394.60
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: \$501.60 Benefit: 75% = \$376.20
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: \$1,182.75 Benefit: 75% = \$887.10
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: \$199.40 Benefit: 75% = \$149.55
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.) <i>(See para T8.81 of explanatory notes to this Category)</i> Fee: \$1,342.20 Benefit: 75% = \$1,006.65
42734	CAPSULOTOMY, other than by laser (Anaes.) (Assist.) Fee: \$265.75 Benefit: 75% = \$199.35 85% = \$225.90
42737	NEEDLING OF POSTERIOR CAPSULE (Anaes.) (Assist.) Fee: \$265.75 Benefit: 75% = \$199.35 85% = \$225.90
‡ 42740	PARACENTESIS OF ANTERIOR OR POSTERIOR SEGMENT (including the vitreous) 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: \$265.75 Benefit: 75% = \$199.35 85% = \$225.90
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) Fee: \$558.25 Benefit: 75% = \$418.70 85% = \$494.35
42744	NEEDLING FOR DRAINAGE OF ENCYSTED BLEB, following trabeculectomy (Anaes.) Fee: \$265.55 Benefit: 75% = \$199.20 85% = \$225.75
42746	GLAUCOMA, filtering operation for (Anaes.) (Assist.) Fee: \$843.85 Benefit: 75% = \$632.90
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) Fee: \$1,056.55 Benefit: 75% = \$792.45
42752	GLAUCOMA, insertion of Molteno valve for, 1 or more stages (Anaes.) (Assist.) Fee: \$1,182.75 Benefit: 75% = \$887.10
42755	GLAUCOMA, removal of Molteno valve (Anaes.) Fee: \$146.20 Benefit: 75% = \$109.65 85% = \$124.30
42758	GONIOTOMY (Anaes.) (Assist.) Fee: \$618.05 Benefit: 75% = \$463.55
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) Fee: \$458.50 Benefit: 75% = \$343.90 85% = \$394.60
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) Fee: \$458.50 Benefit: 75% = \$343.90 85% = \$394.60

OPERATIONS	OPHTHALMOLOGY
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) Fee: \$963.45 Benefit: 75% = \$722.60
42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) <i>(See para T8.82 of explanatory notes to this Category)</i> Fee: \$260.55 Benefit: 75% = \$195.45 85% = \$221.50
42771	CYCLODESTRUCTIVE PROCEDURES for the treatment of intractable glaucoma, treatment to one eye - <i>where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which 42770 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) <i>(See para T8.82 of explanatory notes to this Category)</i> Fee: \$256.50 Benefit: 75% = \$192.40 85% = \$218.05
42773	DETACHED RETINA, diathermy or cryotherapy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) Fee: \$797.35 Benefit: 75% = \$598.05 85% = \$733.45
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) Fee: \$1,182.75 Benefit: 75% = \$887.10
42779	DETACHED RETINA, revision operation for (Anaes.) (Assist.) Fee: \$1,475.20 Benefit: 75% = \$1,106.40
42782	LASER TRABECULOPLASTY - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.) <i>(See para T8.83 of explanatory notes to this Category)</i> Fee: \$398.65 Benefit: 75% = \$299.00 85% = \$338.90
42783	LASER TRABECULOPLASTY - each treatment to 1 eye - <i>where it can be demonstrated that a 5th or subsequent treatment to that eye (including any treatments to which item 42782 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) <i>(See para T8.83 of explanatory notes to this Category)</i> Fee: \$398.65 Benefit: 75% = \$299.00 85% = \$338.90
‡ 42785	LASER IRIDOTOMY - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) <i>(See para T8.84 of explanatory notes to this Category)</i> Fee: \$312.25 Benefit: 75% = \$234.20 85% = \$265.45
‡ 42786	LASER IRIDOTOMY - each treatment episode to 1 eye - <i>where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) <i>(See para T8.84 of explanatory notes to this Category)</i> Fee: \$312.25 Benefit: 75% = \$234.20 85% = \$265.45
‡ 42788	LASER CAPSULOTOMY - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) <i>(See para T8.85 of explanatory notes to this Category)</i> Fee: \$312.25 Benefit: 75% = \$234.20 85% = \$265.45
‡ 42789	LASER CAPSULOTOMY - each treatment episode to 1 eye - <i>where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) <i>(See para T8.85 of explanatory notes to this Category)</i> Fee: \$312.25 Benefit: 75% = \$234.20 85% = \$265.45
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.) <i>(See para T8.86 of explanatory notes to this Category)</i> Fee: \$312.25 Benefit: 75% = \$234.20 85% = \$265.45
42792	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS - each treatment to 1 eye - <i>where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) <i>(See para T8.86 of explanatory notes to this Category)</i> Fee: \$312.25 Benefit: 75% = \$234.20 85% = \$265.45

OPERATIONS		OPHTHALMOLOGY	
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 T8.87 of explanatory notes to this Category) Fee: \$59.80 Benefit: 75% = \$44.85 85% = \$50.85		
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 T8.88 of explanatory notes to this Category) Fee: \$59.80 Benefit: 75% = \$44.85 85% = \$50.85		
† 42801	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.) Fee: \$927.60 Benefit: 75% = \$695.70		
† 42802	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.) Fee: \$463.60 Benefit: 75% = \$347.70		
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: \$518.20 Benefit: 75% = \$388.65 85% = \$454.30		
42806	IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) Fee: \$312.25 Benefit: 75% = \$234.20 85% = \$265.45		
42807	PHOTOMYDRIASIS, laser Fee: \$314.40 Benefit: 75% = \$235.80 85% = \$267.25		
42808	PHOTOIRIDOSYNERESIS, laser Fee: \$314.40 Benefit: 75% = \$235.80 85% = \$267.25		
42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) Fee: \$398.65 Benefit: 75% = \$299.00 85% = \$338.90		
42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) Fee: \$501.65 Benefit: 75% = \$376.25 85% = \$437.75		
42811	TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) Fee: \$398.65 Benefit: 75% = \$299.00 85% = \$338.90		
42812	DETACHED RETINA, removal of encircling silicone band from (Anaes.) Fee: \$146.20 Benefit: 75% = \$109.65 85% = \$124.30		
42815	POSTERIOR CHAMBER, removal of silicone oil from (Anaes.) (Assist.) Fee: \$558.25 Benefit: 75% = \$418.70		
42818	RETINA, CRYOTHERAPY TO, as an independent procedure, with external probe (Anaes.) Fee: \$518.20 Benefit: 75% = \$388.65 85% = \$454.30		
42821	OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.) Fee: \$79.80 Benefit: 75% = \$59.85 85% = \$67.85		
42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure Fee: \$61.75 Benefit: 75% = \$46.35 85% = \$52.50		
‡ 42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) Fee: \$518.20 Benefit: 75% = \$388.65		
‡ 42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) Fee: \$644.55 Benefit: 75% = \$483.45		

OPERATIONS		OSTEOMYELITIS
‡ 42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) Fee: \$618.05 Benefit: 75% = \$463.55	
‡ 42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 or MORE MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) Fee: \$770.80 Benefit: 75% = \$578.10	
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.) <i>(See para T8.89 of explanatory notes to this Category)</i> Fee: \$167.35 Benefit: 75% = \$125.55 85% = \$142.25	
‡ 42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.) Fee: \$618.05 Benefit: 75% = \$463.55	
‡ 42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) Fee: \$770.80 Benefit: 75% = \$578.10	
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00	
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00	
42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.) Fee: \$797.35 Benefit: 75% = \$598.05 85% = \$733.45	
42863	EYELID, recession of (Anaes.) (Assist.) Fee: \$684.40 Benefit: 75% = \$513.30 85% = \$620.50	
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: \$664.40 Benefit: 75% = \$498.30 85% = \$600.50	
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) Fee: \$485.15 Benefit: 75% = \$363.90 85% = \$421.25	
42872	EYEBROW, elevation of, for parietic states (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS		
OPERATIONS FOR ACUTE OSTEOMYELITIS		
43500	OPERATION ON PHALANX (Anaes.) Fee: \$109.05 Benefit: 75% = \$81.80	
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.) Fee: \$180.85 Benefit: 75% = \$135.65	
43506	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20	
43509	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20	

OPERATIONS	PAEDIATRIC
OPERATIONS FOR CHRONIC OSTEOMYELITIS	
43512	OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20
43515	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20 85% = \$267.70
43518	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45
43521	OPERATION ON SKULL (Anaes.) (Assist.) Fee: \$410.45 Benefit: 75% = \$307.85
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45 85% = \$455.35
SUBGROUP 11 - PAEDIATRIC	
SURGERY IN THE NEONATE OR YOUNG CHILD	
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) Fee: \$845.90 Benefit: 75% = \$634.45
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) Fee: \$900.70 Benefit: 75% = \$675.55
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.) Fee: \$982.60 Benefit: 75% = \$736.95
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) Fee: \$1,146.45 Benefit: 75% = \$859.85
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intestinal perforation with or without meconium peritonitis (Anaes.) (Assist.) Fee: \$1,146.45 Benefit: 75% = \$859.85
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: \$1,064.45 Benefit: 75% = \$798.35
43819	HIRSCHSPRUNG'S DISEASE, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) Fee: \$859.80 Benefit: 75% = \$644.85
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.) Fee: \$859.80 Benefit: 75% = \$644.85
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) Fee: \$982.60 Benefit: 75% = \$736.95
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) Fee: \$1,085.60 Benefit: 75% = \$814.20
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) Fee: \$845.90 Benefit: 75% = \$634.45
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) Fee: \$982.60 Benefit: 75% = \$736.95

OPERATIONS	PAEDIATRIC
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) Fee: \$1,228.20 Benefit: 75% = \$921.15
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: \$1,064.45 Benefit: 75% = \$798.35
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: \$1,637.65 Benefit: 75% = \$1,228.25
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: \$1,760.40 Benefit: 75% = \$1,320.30
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) Fee: \$450.35 Benefit: 75% = \$337.80
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) Fee: \$1,432.85 Benefit: 75% = \$1,074.65 85% = \$1,368.95
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) Fee: \$1,514.85 Benefit: 75% = \$1,136.15
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) Fee: \$532.15 Benefit: 75% = \$399.15 85% = \$468.25
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) Fee: \$1,473.90 Benefit: 75% = \$1,105.45
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.) Fee: \$1,105.45 Benefit: 75% = \$829.10
43867	GASTROSCHISIS, secondary operation for, with removal of silo and closure of abdominal wall (Anaes.) (Assist.) Fee: \$614.20 Benefit: 75% = \$460.65
43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) Fee: \$859.80 Benefit: 75% = \$644.85
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) Fee: \$1,146.45 Benefit: 75% = \$859.85
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) Fee: \$982.60 Benefit: 75% = \$736.95
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) Fee: \$1,146.45 Benefit: 75% = \$859.85
43882	CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.) Fee: \$1,473.90 Benefit: 75% = \$1,105.45 85% = \$1,410.00
THORACIC SURGERY	
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) Fee: \$982.60 Benefit: 75% = \$736.95
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) Fee: \$1,637.65 Benefit: 75% = \$1,228.25
43906	OESOPHAGUS, resection of congenital, anastomotic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) Fee: \$1,432.85 Benefit: 75% = \$1,074.65

OPERATIONS		PAEDIATRIC
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) Fee: \$1,432.85 Benefit: 75% = \$1,074.65	
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) Fee: \$1,353.75 Benefit: 75% = \$1,015.35	
43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) Fee: \$1,023.55 Benefit: 75% = \$767.70 85% = \$959.65	
ABDOMINAL SURGERY		
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) Fee: \$393.60 Benefit: 75% = \$295.20	
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) Fee: \$460.70 Benefit: 75% = \$345.55	
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) Fee: \$859.80 Benefit: 75% = \$644.85	
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.) Fee: \$655.10 Benefit: 75% = \$491.35	
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) Fee: \$204.80 Benefit: 75% = \$153.60 85% = \$174.10	
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) Fee: \$859.80 Benefit: 75% = \$644.85	
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) Fee: \$122.90 Benefit: 75% = \$92.20 85% = \$104.50	
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) Fee: \$769.95 Benefit: 75% = \$577.50	
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) Fee: \$941.75 Benefit: 75% = \$706.35	
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) Fee: \$1,023.55 Benefit: 75% = \$767.70	
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.) Fee: \$360.10 Benefit: 75% = \$270.10	
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) Fee: \$1,432.85 Benefit: 75% = \$1,074.65	
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) Fee: \$1,637.65 Benefit: 75% = \$1,228.25	
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) Fee: \$2,251.80 Benefit: 75% = \$1,688.85	
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) Fee: \$1,637.65 Benefit: 75% = \$1,228.25	
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) Fee: \$1,924.30 Benefit: 75% = \$1,443.25	
43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) Fee: \$1,637.65 Benefit: 75% = \$1,228.25	

OPERATIONS	AMPUTATIONS
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) Fee: \$450.35 Benefit: 75% = \$337.80
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) Fee: \$1,146.45 Benefit: 75% = \$859.85
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) Fee: \$1,269.25 Benefit: 75% = \$951.95
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: \$1,555.85 Benefit: 75% = \$1,166.90
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: \$1,678.65 Benefit: 75% = \$1,259.00 85% = \$1,614.75
43996	HIRSCHSPRUNG'S DISEASE, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) Fee: \$1,883.35 Benefit: 75% = \$1,412.55 85% = \$1,819.45
43999	HIRSCHSPRUNG'S DISEASE, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) Fee: \$235.50 Benefit: 75% = \$176.65
44102	RECTUM, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) Fee: \$227.05 Benefit: 75% = \$170.30
44105	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, under general anaesthesia (Anaes.) Fee: \$39.85 Benefit: 75% = \$29.90 85% = \$33.90
44108	INGUINAL HERNIA repair at age less than 3 months (Anaes.) (Assist.) Fee: \$434.30 Benefit: 75% = \$325.75
44111	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair of, at age less than 3 months, including orchidopexy when performed (Anaes.) (Assist.) Fee: \$508.60 Benefit: 75% = \$381.45 85% = \$444.70
44114	INGUINAL HERNIA repair at age less than 3 months when orchidopexy also required (Anaes.) (Assist.) Fee: \$508.60 Benefit: 75% = \$381.45
MISCELLANEOUS SURGERY	
44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) Fee: \$409.40 Benefit: 75% = \$307.05 85% = \$348.00
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) Fee: \$324.95 Benefit: 75% = \$243.75
44136	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35
SUBGROUP 12 - AMPUTATIONS	
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95 85% = \$222.10
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20
44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45
44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) Fee: \$1,055.30 Benefit: 75% = \$791.50 85% = \$991.40

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
44338	1 DIGIT of foot, amputation of (Anaes.) Fee: \$127.25 Benefit: 75% = \$95.45 85% = \$108.20		
44342	2 DIGITS of 1 foot, amputation of (Anaes.) Fee: \$194.35 Benefit: 75% = \$145.80		
44346	3 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) Fee: \$224.40 Benefit: 75% = \$168.30		
44350	4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) Fee: \$254.70 Benefit: 75% = \$191.05 85% = \$216.50		
44354	5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) Fee: \$291.45 Benefit: 75% = \$218.60		
44358	TOE, including metatarsal or part of metatarsal each toe, amputation of (Anaes.) Fee: \$162.50 Benefit: 75% = \$121.90		
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: \$233.20 Benefit: 75% = \$174.90		
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20		
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95		
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.) Fee: \$461.15 Benefit: 75% = \$345.90		
44370	AMPUTATION AT HIP (Anaes.) (Assist.) Fee: \$636.40 Benefit: 75% = \$477.30		
44373	HINDQUARTER, amputation of (Anaes.) (Assist.) Fee: \$1,306.40 Benefit: 75% = \$979.80 85% = \$1,242.50		
44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.) Derived Fee: 75% of the original amputation fee		
SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY			
METICULOUS REPAIR DESIGNED TO OBTAIN MAXIMUM FUNCTIONAL RESULTS INCLUDING THE PREPARATION OF THE DEFECT REQUIRING REPAIR			
<i>(Note: See Explanatory notes to this Category for definition of "Local skin flap")</i>			
GENERAL			
45000	SINGLE STAGE LOCAL MUSCLE FLAP REPAIR, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes.) Fee: \$478.40 Benefit: 75% = \$358.80 85% = \$414.50		
45003	SINGLE STAGE LOCAL MYOCUTANEOUS FLAP REPAIR to 1 defect, simple and small (Anaes.) Fee: \$531.60 Benefit: 75% = \$398.70 85% = \$467.70		
45006	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.) Fee: \$916.95 Benefit: 75% = \$687.75		
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.) Fee: \$335.00 Benefit: 75% = \$251.25		
45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.) Fee: \$561.10 Benefit: 75% = \$420.85		

OPERATIONS		PLASTIC & RECONSTRUCTIVE
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.) Fee: \$265.75 Benefit: 75% = \$199.35	
45018	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) Fee: \$418.55 Benefit: 75% = \$313.95 85% = \$355.80	
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 T8.90 of explanatory notes to this Category) Fee: \$350.50 Benefit: 75% = \$262.90	
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 T8.90 of explanatory notes to this Category) Fee: \$350.50 Benefit: 75% = \$262.90 85% = \$297.95	
45021	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) (See para T8.91 of explanatory notes to this Category) Fee: \$156.75 Benefit: 75% = \$117.60 85% = \$133.25	
45024	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) (See para T8.91 of explanatory notes to this Category) Fee: \$352.15 Benefit: 75% = \$264.15 85% = \$299.35	
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 T8.91 of explanatory notes to this Category) Fee: \$156.75 Benefit: 75% = \$117.60 85% = \$133.25	
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 T8.91 of explanatory notes to this Category) Fee: \$352.15 Benefit: 75% = \$264.15 85% = \$299.35	
45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$106.35 Benefit: 75% = \$79.80 85% = \$90.40	
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: \$114.20 Benefit: 75% = \$85.65 85% = \$97.10	
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
45035	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.) Fee: \$620.35 Benefit: 75% = \$465.30	
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.) Fee: \$996.75 Benefit: 75% = \$747.60	
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.) Fee: \$272.50 Benefit: 75% = \$204.40 85% = \$231.65	
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) Fee: \$272.50 Benefit: 75% = \$204.40 85% = \$231.65	

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
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: \$684.40 Benefit: 75% = \$513.30		
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.) <i>(See para T8.92 of explanatory notes to this Category)</i> Fee: \$418.65 Benefit: 75% = \$314.00		
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.) <i>(See para T8.93 of explanatory notes to this Category)</i> Fee: \$217.40 Benefit: 75% = \$163.05		
	SKIN FLAP SURGERY <i>(Note: See Explanatory notes to this Category for definition of "Local skin flap")</i>		
‡ 45200	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.) <i>(See para T8.94 of explanatory notes to this Category)</i> Fee: \$251.25 Benefit: 75% = \$188.45 85% = \$213.60		
‡ 45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.) (Assist.) <i>(See para T8.94 of explanatory notes to this Category)</i> Fee: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00		
‡ 45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, and excluding H-flap or double advancement flap (Anaes.) <i>(See para T8.94 of explanatory notes to this Category)</i> Fee: \$338.95 Benefit: 75% = \$254.25 85% = \$288.15		
† 45207	H-FLAP OR DOUBLE ADVANCEMENT FLAP where indicated to repair 1 defect, on eyelid, eyebrow or forehead (Anaes.) Fee: \$338.95 Benefit: 75% = \$254.25 85% = \$288.15		
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.) Fee: \$418.65 Benefit: 75% = \$314.00 85% = \$355.90		
45212	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (Anaes.) Fee: \$207.70 Benefit: 75% = \$155.80 85% = \$176.55		
45215	DIRECT FLAP REPAIR, cross leg, first stage (Anaes.) (Assist.) Fee: \$896.10 Benefit: 75% = \$672.10		
45218	DIRECT FLAP REPAIR, cross leg, second stage (Anaes.) (Assist.) Fee: \$401.90 Benefit: 75% = \$301.45		
45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.) Fee: \$231.05 Benefit: 75% = \$173.30 85% = \$196.40		
45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.) Fee: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30		
45227	INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.) Fee: \$393.60 Benefit: 75% = \$295.20 85% = \$334.60		
45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.) Fee: \$196.75 Benefit: 75% = \$147.60 85% = \$167.25		
45233	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.) Fee: \$418.65 Benefit: 75% = \$314.00 85% = \$355.90		
45236	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.) Fee: \$328.30 Benefit: 75% = \$246.25		

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
‡ 45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.) Fee: \$231.05	Benefit: 75% = \$173.30	85% = \$196.40
† 45240	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.) Fee: \$231.05	Benefit: 75% = \$173.30	85% = \$196.40
FREE GRAFTS			
45400	FREE GRAFTING (split skin) of a granulating area, small (Anaes.) Fee: \$180.85	Benefit: 75% = \$135.65	85% = \$153.75
45403	FREE GRAFTING (split skin) of a granulating area, extensive (Anaes.) (Assist.) Fee: \$360.10	Benefit: 75% = \$270.10	85% = \$306.10
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.) <i>(See para T8.95 of explanatory notes to this Category)</i> Fee: \$398.65	Benefit: 75% = \$299.00	85% = \$338.90
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.) <i>(See para T8.95 of explanatory notes to this Category)</i> Fee: \$531.60	Benefit: 75% = \$398.70	
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.) <i>(See para T8.95 of explanatory notes to this Category)</i> Fee: \$731.00	Benefit: 75% = \$548.25	
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.) <i>(See para T8.95 of explanatory notes to this Category)</i> Fee: \$797.35	Benefit: 75% = \$598.05	
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.) <i>(See para T8.95 of explanatory notes to this Category)</i> Fee: \$863.80	Benefit: 75% = \$647.85	
45439	FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (Anaes.) Fee: \$251.25	Benefit: 75% = \$188.45	85% = \$213.60
45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.) Fee: \$518.20	Benefit: 75% = \$388.65	85% = \$454.30
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: \$491.85	Benefit: 75% = \$368.90	85% = \$427.95
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: \$332.25	Benefit: 75% = \$249.20	85% = \$282.45
45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.) Fee: \$418.65	Benefit: 75% = \$314.00	85% = \$355.90
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: \$1,107.50	Benefit: 75% = \$830.65	
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: \$789.30	Benefit: 75% = \$592.00	

OPERATIONS	PLASTIC & RECONSTRUCTIVE
45462	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>15 percent or more but less than 20 percent</i> of total body surface - conjoint surgery, co- surgeon (Assist.) Fee: \$595.70 Benefit: 75% = \$446.80
45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>20 percent or more but less than 30 percent</i> of total body surface - one surgeon (Anaes.) (Assist.) Fee: \$1,690.50 Benefit: 75% = \$1,267.90
45465	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>20 percent or more but less than 30 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$1,204.40 Benefit: 75% = \$903.30 85% = \$1,140.50
45466	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>20 percent or more but less than 30 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$908.30 Benefit: 75% = \$681.25 85% = \$844.40
45468	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>30 percent or more but less than 40 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$1,619.40 Benefit: 75% = \$1,214.55
45469	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>30 percent or more but less than 40 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$1,221.80 Benefit: 75% = \$916.35 85% = \$1,157.90
45471	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>40 percent or more but less than 50 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$2,035.55 Benefit: 75% = \$1,526.70 85% = \$1,971.65
45472	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>40 percent or more but less than 50 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$1,535.40 Benefit: 75% = \$1,151.55 85% = \$1,471.50
45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>50 percent or more but less than 60 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$2,450.60 Benefit: 75% = \$1,837.95 85% = \$2,386.70
45475	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>50 percent or more but less than 60 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$1,849.00 Benefit: 75% = \$1,386.75 85% = \$1,785.10
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>60 percent or more but less than 70 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$2,865.70 Benefit: 75% = \$2,149.30 85% = \$2,801.80
45478	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>60 percent or more but less than 70 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$2,161.45 Benefit: 75% = \$1,621.10 85% = \$2,097.55
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>70 percent or more but less than 80 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$3,280.65 Benefit: 75% = \$2,460.50 85% = \$3,216.75
45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>70 percent or more but less than 80 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$2,475.15 Benefit: 75% = \$1,856.40 85% = \$2,411.25
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>80 percent or more</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$3,737.75 Benefit: 75% = \$2,803.35 85% = \$3,673.85
45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>80 percent or more</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$2,820.15 Benefit: 75% = \$2,115.15 85% = \$2,756.25
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: \$466.30 Benefit: 75% = \$349.75

OPERATIONS	PLASTIC & RECONSTRUCTIVE
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: \$398.65 Benefit: 75% = \$299.00
45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.) Fee: \$398.65 Benefit: 75% = \$299.00
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.) Fee: \$598.10 Benefit: 75% = \$448.60 85% = \$534.20
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.) Fee: \$797.45 Benefit: 75% = \$598.10
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.) Fee: \$996.75 Benefit: 75% = \$747.60
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.) Fee: \$1,196.10 Benefit: 75% = \$897.10
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10
45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.) Fee: \$1,448.00 Benefit: 75% = \$1,086.00 85% = \$1,384.10
OTHER GRAFTS AND MISCELLANEOUS PROCEDURES	
45496	FLAP, free tissue transfer using microvascular techniques - <i>revision of</i> , by open operation (Anaes.) Fee: \$367.60 Benefit: 75% = \$275.70
‡ 45497	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>complete revision of</i> , by liposuction (Anaes.) Fee: \$287.15 Benefit: 75% = \$215.40
‡ 45498	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>staged revision of</i> , by liposuction - first stage (Anaes.) Fee: \$231.05 Benefit: 75% = \$173.30
‡ 45499	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>staged revision of</i> , by liposuction - second stage (Anaes.) Fee: \$172.30 Benefit: 75% = \$129.25
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) Fee: \$963.45 Benefit: 75% = \$722.60
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) Fee: \$1,568.20 Benefit: 75% = \$1,176.15
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) Fee: \$1,568.20 Benefit: 75% = \$1,176.15
45503	MICRO-ARTERIAL OR MICRO-VEINOUS GRAFT using microsurgical techniques (Anaes.) (Assist.) Fee: \$1,794.15 Benefit: 75% = \$1,345.65
45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) Fee: \$1,568.20 Benefit: 75% = \$1,176.15

OPERATIONS	PLASTIC & RECONSTRUCTIVE
45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) Fee: \$1,568.20 Benefit: 75% = \$1,176.15
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.) <i>(See para T8.96 of explanatory notes to this Category)</i> Fee: \$194.35 Benefit: 75% = \$145.80 85% = \$165.20
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.) <i>(See para T8.96 of explanatory notes to this Category)</i> Fee: \$261.25 Benefit: 75% = \$195.95 85% = \$222.10
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.) <i>(See para T8.96 of explanatory notes to this Category)</i> Fee: \$164.80 Benefit: 75% = \$123.60 85% = \$140.10
45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes.) <i>(See para T8.96 of explanatory notes to this Category)</i> Fee: \$199.40 Benefit: 75% = \$149.55 85% = \$169.50
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.) Fee: \$379.15 Benefit: 75% = \$284.40
45520	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple (Anaes.) (Assist.) Fee: \$795.65 Benefit: 75% = \$596.75
‡ 45522	REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia (Anaes.) (Assist.) <i>(See para T8.97 of explanatory notes to this Category)</i> Fee: \$558.25 Benefit: 75% = \$418.70 85% = \$494.35
45524	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast (Anaes.) (Assist.) <i>(See para T8.98 of explanatory notes to this Category)</i> Fee: \$655.40 Benefit: 75% = \$491.55
45527	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (Anaes.) (Assist.) <i>(See para T8.98 of explanatory notes to this Category)</i> Fee: \$655.40 Benefit: 75% = \$491.55
45528	MAMMAPLASTY, AUGMENTATION, bilateral, <u>not being a service to which Item 45527 applies, where it can be demonstrated</u> 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.) <i>(See para T8.98 of explanatory notes to this Category)</i> Fee: \$982.95 Benefit: 75% = \$737.25
‡ 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, not being a service associated with a service to which items 30165, 30168, 30171, 30174 or 30177 applies (Anaes.) (Assist.) <i>(See para T8.99 of explanatory notes to this Category)</i> Fee: \$971.50 Benefit: 75% = \$728.65
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: \$1,100.25 Benefit: 75% = \$825.20
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, inseting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.) Fee: \$404.55 Benefit: 75% = \$303.45

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) Fee: \$946.60 Benefit: 75% = \$709.95		
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.) Fee: \$542.00 Benefit: 75% = \$406.50		
45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.) <i>(See para T8.102 of explanatory notes to this Category)</i> Fee: \$550.05 Benefit: 75% = \$412.55 85% = \$486.15		
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple <i>(See para T8.102 of explanatory notes to this Category)</i> Fee: \$174.85 Benefit: 75% = \$131.15 85% = \$148.65		
45548	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.) Fee: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90		
‡ 45551	BREAST PROSTHESIS, removal of, with excision of fibrous capsule (Anaes.) (Assist.) Fee: \$392.05 Benefit: 75% = \$294.05		
‡ 45552	BREAST PROSTHESIS, removal of, with excision of fibrous capsule and replacement of prosthesis (Anaes.) (Assist.) <i>(See para T8.100 of explanatory notes to this Category)</i> Fee: \$564.40 Benefit: 75% = \$423.30 85% = \$500.50		
† 45553	BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation). (Anaes.) (Assist.) <i>(See para T8.100 of explanatory notes to this Category)</i> Fee: \$564.40 Benefit: 75% = \$423.30 85% = \$500.50		
‡ 45554	BREAST PROSTHESIS, removal and replacement with another prosthesis, 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.) <i>(See para T8.100 of explanatory notes to this Category)</i> Fee: \$618.05 Benefit: 75% = \$463.55 85% = \$554.15		
45555	SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes.) (Assist.) <i>(See para T8.100 of explanatory notes to this Category)</i> Fee: \$564.40 Benefit: 75% = \$423.30		
45556	BREAST PTOSIS, correction of (unilateral), to match the position of the contralateral breast (Anaes.) (Assist.) <i>(See para T8.101 of explanatory notes to this Category)</i> Fee: \$676.85 Benefit: 75% = \$507.65 85% = \$612.95		
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.) <i>(See para T8.101 of explanatory notes to this Category)</i> Fee: \$676.85 Benefit: 75% = \$507.65		
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.) <i>(See para T8.101 of explanatory notes to this Category)</i> Fee: \$1,015.30 Benefit: 75% = \$761.50		
† 45559	TUBEROUS, TUBULAR OR CONSTRICTED BREAST, where it can be demonstrated , correction of by simultaneous mastopexy and augmentation of (unilateral) (Anaes.) (Assist.) <i>(See para T8.101 of explanatory notes to this Category)</i> Fee: \$1,004.55 Benefit: 75% = \$753.45 85% = \$940.65		
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: \$418.55 Benefit: 75% = \$313.95 85% = \$355.80		

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45562	FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) Fee: \$971.50 Benefit: 75% = \$728.65 85% = \$907.60		
45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) Fee: \$971.50 Benefit: 75% = \$728.65 85% = \$907.60		
45564	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, inseting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, principal specialist surgeon (Anaes.) (Assist.) Fee: \$2,250.00 Benefit: 75% = \$1,687.50		
45565	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, inseting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, conjoint specialist surgeon (Assist.) Fee: \$1,687.55 Benefit: 75% = \$1,265.70		
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: \$946.60 Benefit: 75% = \$709.95		
45568	TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.) Fee: \$392.05 Benefit: 75% = \$294.05		
‡ *	CLOSURE OF ABDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.) Fee: \$598.75 Benefit: 75% = \$449.10		
†	CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.) Fee: \$808.50 Benefit: 75% = \$606.40 85% = \$744.60		
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: \$257.80 Benefit: 75% = \$193.35 85% = \$219.15		
45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) Fee: \$636.40 Benefit: 75% = \$477.30 85% = \$572.50		
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) Fee: \$737.05 Benefit: 75% = \$552.80		
45581	FACIAL NERVE PALSY, excision of tissue for (Anaes.) Fee: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90		
45584	LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.) <i>(See para T8.103 of explanatory notes to this Category)</i> Fee: \$558.25 Benefit: 75% = \$418.70 85% = \$494.35		
‡ 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, lymphoedema or macrodystrophia lipomatosa (Anaes.) <i>(See para T8.103 of explanatory notes to this Category)</i> Fee: \$558.25 Benefit: 75% = \$418.70 85% = \$494.35		
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.) <i>(See para T8.103 of explanatory notes to this Category)</i> Fee: \$558.25 Benefit: 75% = \$418.70		

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
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 T8.104 of explanatory notes to this Category)	Fee: \$787.20	Benefit: 75% = \$590.40 85% = \$723.30
45588	MELOPLASTY, (excluding browlifts and chinlift platysmaplasties), bilateral <i>where it can be demonstrated</i> that surgery is indicated because of congenital conditions, disease or trauma (other than trauma resulting from previous elective cosmetic surgery) (Anaes.) (Assist.) (See para T8.104 of explanatory notes to this Category)	Fee: \$1,180.90	Benefit: 75% = \$885.70
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.)	Fee: \$427.05	Benefit: 75% = \$320.30
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.)	Fee: \$501.60	Benefit: 75% = \$376.20
45596	MAXILLA, total resection of (Anaes.) (Assist.)	Fee: \$795.65	Benefit: 75% = \$596.75
45597	MAXILLA, total resection of both maxillae (Anaes.) (Assist.)	Fee: \$1,065.10	Benefit: 75% = \$798.85
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.)	Fee: \$827.60	Benefit: 75% = \$620.70 85% = \$763.70
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.)	Fee: \$618.05	Benefit: 75% = \$463.55
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.)	Fee: \$519.25	Benefit: 75% = \$389.45
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.)	Fee: \$731.00	Benefit: 75% = \$548.25
45611	MANDIBLE, condylectomy (Anaes.) (Assist.)	Fee: \$418.65	Benefit: 75% = \$314.00
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.)	Fee: \$519.25	Benefit: 75% = \$389.45 85% = \$455.35
45617	UPPER EYELID, REDUCTION OF, for skin redundancy obscuring vision (as evidenced by upper eyelid skin resting on lashes on straight ahead gaze), herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of 1 of these conditions (Anaes.) (See para T8.105 of explanatory notes to this Category)	Fee: \$207.70	Benefit: 75% = \$155.80 85% = \$176.55
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 T8.105 of explanatory notes to this Category)	Fee: \$288.10	Benefit: 75% = \$216.10 85% = \$244.90
45623	PTOSIS of eyelid (unilateral), correction of (Anaes.) (Assist.)	Fee: \$638.95	Benefit: 75% = \$479.25 85% = \$575.05
45624	PTOSIS of eyelid, correction of, where previous ptosis surgery has been performed on that side (Anaes.) (Assist.)	Fee: \$828.35	Benefit: 75% = \$621.30 85% = \$764.45
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: \$165.70	Benefit: 75% = \$124.30
45626	ECTROPION OR ENTROPION, correction of (unilateral) (Anaes.)	Fee: \$288.10	Benefit: 75% = \$216.10 85% = \$244.90

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45629	SYMBLEPHARON, grafting for (Anaes.) (Assist.) Fee: \$418.65 Benefit: 75% = \$314.00 85% = \$355.90		
45632	RHINOPLASTY, correction of lateral or alar cartilages (Anaes.) Fee: \$452.35 Benefit: 75% = \$339.30 85% = \$388.45		
45635	RHINOPLASTY, correction of bony vault only (Anaes.) Fee: \$519.25 Benefit: 75% = \$389.45 85% = \$455.35		
45638	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, for correction of nasal obstruction or post-traumatic deformity (<i>but not as a result of previous elective cosmetic surgery</i>), or both (Anaes.) (See para T8.106 of explanatory notes to this Category) Fee: \$896.10 Benefit: 75% = \$672.10 85% = \$832.20		
45639	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, <i>where it can be demonstrated</i> that there is a need for correction of significant developmental deformity (Anaes.) (See para T8.106 of explanatory notes to this Category) Fee: \$896.10 Benefit: 75% = \$672.10 85% = \$832.20		
45641	RHINOPLASTY involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (Anaes.) Fee: \$956.90 Benefit: 75% = \$717.70 85% = \$893.00		
45644	RHINOPLASTY involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,130.60 Benefit: 75% = \$847.95 85% = \$1,066.70		
45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.) Fee: \$197.60 Benefit: 75% = \$148.20		
45646	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.) Fee: \$795.65 Benefit: 75% = \$596.75 85% = \$731.75		
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 T8.107 of explanatory notes to this Category) Fee: \$1,130.60 Benefit: 75% = \$847.95		
45650	RHINOPLASTY, secondary revision of (Anaes.) Fee: \$130.65 Benefit: 75% = \$98.00 85% = \$111.10		
45652	RHINOPHYMA, carbon dioxide laser or erbium laser excision-ablation of (Anaes.) Fee: \$314.90 Benefit: 75% = \$236.20 85% = \$267.70		
45653	RHINOPHYMA, shaving of (Anaes.) Fee: \$314.90 Benefit: 75% = \$236.20 85% = \$267.70		
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) Fee: \$443.85 Benefit: 75% = \$332.90 85% = \$379.95		
45659	LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (Anaes.) Fee: \$460.55 Benefit: 75% = \$345.45 85% = \$396.65		
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: \$2,543.80 Benefit: 75% = \$1,907.85		
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: \$1,130.60 Benefit: 75% = \$847.95		
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.) Fee: \$619.65 Benefit: 75% = \$464.75		

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.) Fee: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90		
45668	VERMILIONECTOMY, by surgical excision (Anaes.) Fee: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90		
45669	VERMILIONECTOMY, using carbon dioxide laser or erbium laser excision-ablation (Anaes.) <i>(See para T8.108 of explanatory notes to this Category)</i> Fee: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90		
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) Fee: \$737.05 Benefit: 75% = \$552.80 85% = \$673.15		
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) Fee: \$214.35 Benefit: 75% = \$160.80 85% = \$182.20		
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) Fee: \$427.05 Benefit: 75% = \$320.30		
45676	MACROSTOMIA, operation for (Anaes.) (Assist.) Fee: \$508.35 Benefit: 75% = \$381.30		
45677	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$478.40 Benefit: 75% = \$358.80		
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$598.10 Benefit: 75% = \$448.60		
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$664.40 Benefit: 75% = \$498.30		
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$784.20 Benefit: 75% = \$588.15		
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) Fee: \$231.25 Benefit: 75% = \$173.45		
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) Fee: \$265.75 Benefit: 75% = \$199.35 85% = \$225.90		
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) Fee: \$431.90 Benefit: 75% = \$323.95		
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.) Fee: \$405.35 Benefit: 75% = \$304.05		
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) Fee: \$731.00 Benefit: 75% = \$548.25		
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) Fee: \$265.75 Benefit: 75% = \$199.35 85% = \$225.90		
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) Fee: \$690.95 Benefit: 75% = \$518.25		
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) Fee: \$431.90 Benefit: 75% = \$323.95		
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) Fee: \$491.85 Benefit: 75% = \$368.90		
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.) Fee: \$690.95 Benefit: 75% = \$518.25		

OPERATIONS	PLASTIC & RECONSTRUCTIVE
45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) Fee: \$690.95 Benefit: 75% = \$518.25
45720	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$854.25 Benefit: 75% = \$640.70 85% = \$790.35
45723	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$963.45 Benefit: 75% = \$722.60
45726	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$1,088.70 Benefit: 75% = \$816.55
45729	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$1,222.65 Benefit: 75% = \$917.00
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.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$1,239.50 Benefit: 75% = \$929.65
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.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$1,395.45 Benefit: 75% = \$1,046.60
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.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$1,423.60 Benefit: 75% = \$1,067.70
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.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$1,601.50 Benefit: 75% = \$1,201.15
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.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$1,566.10 Benefit: 75% = \$1,174.60
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.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$1,760.80 Benefit: 75% = \$1,320.60
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.) <i>(See para T8.109 of explanatory notes to this Category)</i> Fee: \$1,708.55 Benefit: 75% = \$1,281.45 85% = \$1,644.65

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
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.) <i>(See para T8.109 of explanatory notes to this Category)</i>	Fee: \$1,913.75	Benefit: 75% = \$1,435.35
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: \$1,925.15	Benefit: 75% = \$1,443.90 85% = \$1,861.25
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: \$2,307.70	Benefit: 75% = \$1,730.80
‡ 45755	TEMPOROMANDIBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.)	Fee: \$324.95	Benefit: 75% = \$243.75 85% = \$276.25
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.)	Fee: \$581.50	Benefit: 75% = \$436.15
45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) <i>(See para T8.110 of explanatory notes to this Category)</i>	Fee: \$661.55	Benefit: 75% = \$496.20
45767	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.)	Fee: \$2,219.35	Benefit: 75% = \$1,664.55 85% = \$2,155.45
45770	HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.)	Fee: \$1,700.05	Benefit: 75% = \$1,275.05
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.)	Fee: \$1,549.35	Benefit: 75% = \$1,162.05 85% = \$1,485.45
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.)	Fee: \$1,549.35	Benefit: 75% = \$1,162.05
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.)	Fee: \$1,139.10	Benefit: 75% = \$854.35
45782	FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.)	Fee: \$871.05	Benefit: 75% = \$653.30 85% = \$807.15
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turriccephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.)	Fee: \$1,473.95	Benefit: 75% = \$1,105.50
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes.) (Assist.)	Fee: \$1,457.20	Benefit: 75% = \$1,092.90
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.)	Fee: \$787.20	Benefit: 75% = \$590.40
‡ 45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.)	Fee: \$445.25	Benefit: 75% = \$333.95 85% = \$381.35
‡ 45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.)	Fee: \$164.80	Benefit: 75% = \$123.60 85% = \$140.10

OPERATIONS		PLASTIC & RECONSTRUCTIVE
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: \$26.05 Benefit: 75% = \$19.55 85% = \$22.15	
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.) <i>(See para T8.111 of explanatory notes to this Category)</i> Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35	
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.) <i>(See para T8.111 of explanatory notes to this Category)</i> Fee: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90	
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.) <i>(See para T8.111 of explanatory notes to this Category)</i> Fee: \$152.45 Benefit: 75% = \$114.35 85% = \$129.60	
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.) <i>(See para T8.111 of explanatory notes to this Category)</i> Fee: \$217.80 Benefit: 75% = \$163.35 85% = \$185.15	
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.) <i>(See para T8.111 of explanatory notes to this Category)</i> Fee: \$328.30 Benefit: 75% = \$246.25 85% = \$279.10	
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.) <i>(See para T8.111 of explanatory notes to this Category)</i> Fee: \$443.85 Benefit: 75% = \$332.90 85% = \$379.95	
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.) <i>(See para T8.111 of explanatory notes to this Category)</i> Fee: \$519.25 Benefit: 75% = \$389.45 85% = \$455.35	
45815	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20 85% = \$267.70	
45817	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) Fee: \$410.45 Benefit: 75% = \$307.85 85% = \$348.90	
45819	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.) Fee: \$519.20 Benefit: 75% = \$389.40 85% = \$455.30	
45821	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.) Fee: \$336.45 Benefit: 75% = \$252.35 85% = \$286.00	

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45823	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, <u>removal of</u> , requiring general anaesthesia where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$96.25 Benefit: 75% = \$72.20 85% = \$81.85		
45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) Fee: \$298.95 Benefit: 75% = \$224.25 85% = \$254.15		
45827	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) Fee: \$285.80 Benefit: 75% = \$214.35 85% = \$242.95		
45829	MAXILLARY TUBerosITY, reduction of (Anaes.) Fee: \$218.00 Benefit: 75% = \$163.50 85% = \$185.30		
45831	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) Fee: \$285.80 Benefit: 75% = \$214.35 85% = \$242.95		
45833	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00		
45835	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) Fee: \$445.25 Benefit: 75% = \$333.95 85% = \$381.35		
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) Fee: \$518.20 Benefit: 75% = \$388.65 85% = \$454.30		
45839	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) Fee: \$518.20 Benefit: 75% = \$388.65 85% = \$454.30		
45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) Fee: \$418.55 Benefit: 75% = \$313.95 85% = \$355.80		
45843	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) Fee: \$256.70 Benefit: 75% = \$192.55 85% = \$218.20		
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: \$445.25 Benefit: 75% = \$333.95 85% = \$381.35		
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: \$164.80 Benefit: 75% = \$123.60 85% = \$140.10		
45849	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) Fee: \$513.25 Benefit: 75% = \$384.95 85% = \$449.35		
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: \$126.30 Benefit: 75% = \$94.75 85% = \$107.40		
45853	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) Fee: \$787.20 Benefit: 75% = \$590.40 85% = \$723.30		
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: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00		
45857	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes.) (Assist.) Fee: \$577.70 Benefit: 75% = \$433.30 85% = \$513.80		

OPERATIONS	HAND SURGERY
45859	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45 85% = \$247.60
45861	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$770.80 Benefit: 75% = \$578.10 85% = \$706.90
45863	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$854.45 Benefit: 75% = \$640.85 85% = \$790.55
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) Fee: \$256.70 Benefit: 75% = \$192.55 85% = \$218.20
45867	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) Fee: \$276.00 Benefit: 75% = \$207.00 85% = \$234.60
‡ 45869	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$1,049.95 Benefit: 75% = \$787.50 85% = \$986.05
45871	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$1,182.75 Benefit: 75% = \$887.10 85% = \$1,118.85
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: \$1,329.00 Benefit: 75% = \$996.75 85% = \$1,265.10
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: \$415.90 Benefit: 75% = \$311.95 85% = \$353.55
45877	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) Fee: \$415.90 Benefit: 75% = \$311.95 85% = \$353.55
45879	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) Fee: \$276.00 Benefit: 75% = \$207.00 85% = \$234.60
SUBGROUP 14 - HAND SURGERY	
<i>Note: Items 46300 to 46534 are restricted to surgery on the hand/s.</i>	
46300	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of (Anaes.) (Assist.) Fee: \$299.00 Benefit: 75% = \$224.25
46303	CARPOMETACARPAL JOINT, arthrodesis of (Anaes.) (Assist.) Fee: \$332.35 Benefit: 75% = \$249.30
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) Fee: \$465.20 Benefit: 75% = \$348.90
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) Fee: \$465.20 Benefit: 75% = \$348.90
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.) Fee: \$465.20 Benefit: 75% = \$348.90

OPERATIONS		HAND SURGERY	
46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.) Fee: \$598.20 Benefit: 75% = \$448.65		
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.) (Assist.) Fee: \$797.50 Benefit: 75% = \$598.15		
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.) (Assist.) Fee: \$996.95 Benefit: 75% = \$747.75		
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: \$1,196.40 Benefit: 75% = \$897.30 85% = \$1,132.50		
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.) Fee: \$713.40 Benefit: 75% = \$535.05		
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: \$744.45 Benefit: 75% = \$558.35		
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.) Fee: \$179.55 Benefit: 75% = \$134.70 85% = \$152.65		
‡ 46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular repair with or without arthrotomy (Anaes.) (Assist.) Fee: \$305.80 Benefit: 75% = \$229.35		
46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.) Fee: \$498.45 Benefit: 75% = \$373.85		
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: \$232.70 Benefit: 75% = \$174.55 85% = \$197.80		
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.) Fee: \$411.95 Benefit: 75% = \$309.00 85% = \$350.20		
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes.) (Assist.) Fee: \$411.95 Benefit: 75% = \$309.00		
46345	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.) Fee: \$498.45 Benefit: 75% = \$373.85		
46348	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes.) Fee: \$216.00 Benefit: 75% = \$162.00 85% = \$183.60		
46351	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.) Fee: \$322.35 Benefit: 75% = \$241.80		
46354	DIGIT, synovectomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.) Fee: \$432.00 Benefit: 75% = \$324.00		
46357	DIGIT, synovectomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.) Fee: \$538.35 Benefit: 75% = \$403.80 85% = \$474.45		
46360	DIGIT, synovectomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.) Fee: \$648.00 Benefit: 75% = \$486.00		
46363	TENDON SHEATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS (Anaes.) Fee: \$186.10 Benefit: 75% = \$139.60 85% = \$158.20		

OPERATIONS		HAND SURGERY
46366	DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.) Fee: \$113.00 Benefit: 75% = \$84.75 85% = \$96.05	
46369	DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.) Fee: \$186.10 Benefit: 75% = \$139.60 85% = \$158.20	
46372	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Anaes.) (Assist.) Fee: \$378.10 Benefit: 75% = \$283.60 85% = \$321.40	
46375	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) Fee: \$448.65 Benefit: 75% = \$336.50 85% = \$384.75	
46378	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) Fee: \$598.20 Benefit: 75% = \$448.65	
46381	INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture - each procedure (Anaes.) (Assist.) Fee: \$265.80 Benefit: 75% = \$199.35	
46384	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (Anaes.) (Assist.) Fee: \$265.80 Benefit: 75% = \$199.35	
46387	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes.) (Assist.) Fee: \$548.40 Benefit: 75% = \$411.30 85% = \$484.50	
46390	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) Fee: \$731.15 Benefit: 75% = \$548.40	
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) Fee: \$847.40 Benefit: 75% = \$635.55	
46396	PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45 85% = \$247.60	
46399	PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.) (Assist.) Fee: \$457.60 Benefit: 75% = \$343.20	
46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.) (Assist.) Fee: \$457.60 Benefit: 75% = \$343.20	
46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.) (Assist.) Fee: \$558.35 Benefit: 75% = \$418.80	
46408	TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.) Fee: \$611.55 Benefit: 75% = \$458.70	
46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.) Fee: \$358.90 Benefit: 75% = \$269.20	
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.) (Assist.) Fee: \$465.10 Benefit: 75% = \$348.85 85% = \$401.20	
46417	TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.) Fee: \$432.00 Benefit: 75% = \$324.00	
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.) Fee: \$180.75 Benefit: 75% = \$135.60 85% = \$153.65	
46423	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.) Fee: \$289.10 Benefit: 75% = \$216.85 85% = \$245.75	

OPERATIONS	HAND SURGERY
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) Fee: \$299.00 Benefit: 75% = \$224.25
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) Fee: \$365.50 Benefit: 75% = \$274.15 85% = \$310.70
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) Fee: \$398.85 Benefit: 75% = \$299.15
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) Fee: \$465.20 Benefit: 75% = \$348.90
46438	MALLET FINGER, closed pin fixation of (Anaes.) Fee: \$119.65 Benefit: 75% = \$89.75 85% = \$101.75
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.) Fee: \$289.10 Benefit: 75% = \$216.85 85% = \$245.75
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) Fee: \$248.15 Benefit: 75% = \$186.15
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.) Fee: \$432.00 Benefit: 75% = \$324.00
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.) Fee: \$538.35 Benefit: 75% = \$403.80
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) Fee: \$199.40 Benefit: 75% = \$149.55
46453	FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.) Fee: \$332.35 Benefit: 75% = \$249.30
46456	FINGER, percutaneous tenotomy of (Anaes.) Fee: \$86.40 Benefit: 75% = \$64.80 85% = \$73.45
46459	OPERATION for OSTEOMYELITIS on distal phalanx (Anaes.) Fee: \$166.20 Benefit: 75% = \$124.65 85% = \$141.30
46462	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.) Fee: \$265.80 Benefit: 75% = \$199.35 85% = \$225.95
46464	AMPUTATION of a supernumerary complete digit (Anaes.) Fee: \$199.40 Benefit: 75% = \$149.55 85% = \$169.50
46465	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) Fee: \$199.40 Benefit: 75% = \$149.55 85% = \$169.50
46468	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) Fee: \$348.95 Benefit: 75% = \$261.75
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) Fee: \$498.45 Benefit: 75% = \$373.85 85% = \$434.55
46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) Fee: \$648.00 Benefit: 75% = \$486.00
46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) Fee: \$797.50 Benefit: 75% = \$598.15

OPERATIONS	HAND SURGERY
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: \$332.35 Benefit: 75% = \$249.30 85% = \$282.50
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.) Fee: \$265.80 Benefit: 75% = \$199.35 85% = \$225.95
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: \$199.40 Benefit: 75% = \$149.55 85% = \$169.50
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: \$232.70 Benefit: 75% = \$174.55 85% = \$197.80
46492	CONTRACTURE OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes.) (Assist.) Fee: \$319.05 Benefit: 75% = \$239.30
46494	GANGLION OF HAND, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$194.35 Benefit: 75% = \$145.80 85% = \$165.20
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: \$179.55 Benefit: 75% = \$134.70 85% = \$152.65
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: \$194.35 Benefit: 75% = \$145.80 85% = \$165.20
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: \$232.70 Benefit: 75% = \$174.55 85% = \$197.80
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: \$290.85 Benefit: 75% = \$218.15 85% = \$247.25
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: \$267.65 Benefit: 75% = \$200.75 85% = \$227.55
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: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20
46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.) Fee: \$976.95 Benefit: 75% = \$732.75 85% = \$913.05
46507	DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.) Fee: \$1,136.50 Benefit: 75% = \$852.40
46510	MACRODACTYLY, surgical reduction of enlarged elements - each digit (Anaes.) (Assist.) Fee: \$310.20 Benefit: 75% = \$232.65
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies (Anaes.) Fee: \$49.95 Benefit: 75% = \$37.50 85% = \$42.50
46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80
46519	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.) Fee: \$124.80 Benefit: 75% = \$93.60 85% = \$106.10

OPERATIONS	ORTHOPAEDIC
46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB, open operation and drainage for infection (Anaes.) (Assist.) Fee: \$372.20 Benefit: 75% = \$279.15
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: \$49.95 Benefit: 75% = \$37.50 85% = \$42.50
46528	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, unguual fold and portion of the nail bed (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) Fee: \$75.25 Benefit: 75% = \$56.45 85% = \$64.00
46534	NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85
SUBGROUP 15 - ORTHOPAEDIC	
TREATMENT OF DISLOCATIONS <i>(Note: See paragraph T8.112 of explanatory notes to this Category)</i>	
47000	MANDIBLE, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15
47003	CLAVICLE, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$74.90 Benefit: 75% = \$56.20 85% = \$63.70
47006	CLAVICLE, treatment of dislocation of, by open reduction (Anaes.) Fee: \$150.45 Benefit: 75% = \$112.85 85% = \$127.90
47009	SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.) (Assist.) Fee: \$299.45 Benefit: 75% = \$224.60
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia Fee: \$74.90 Benefit: 75% = \$56.20 85% = \$63.70
47018	ELBOW, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$174.60 Benefit: 75% = \$130.95 85% = \$148.45
47021	ELBOW, treatment of dislocation of, by open reduction (Anaes.) (Assist.) Fee: \$232.95 Benefit: 75% = \$174.75
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: \$174.60 Benefit: 75% = \$130.95 85% = \$148.45
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: \$232.95 Benefit: 75% = \$174.75
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$174.60 Benefit: 75% = \$130.95 85% = \$148.45
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes.) (Assist.) Fee: \$232.95 Benefit: 75% = \$174.75 85% = \$198.05
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$74.90 Benefit: 75% = \$56.20 85% = \$63.70

OPERATIONS		ORTHOPAEDIC
47039	INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80	
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80	
47045	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) Fee: \$133.20 Benefit: 75% = \$99.90 85% = \$113.25	
47048	HIP, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$287.00 Benefit: 75% = \$215.25 85% = \$243.95	
47051	HIP, treatment of dislocation of, by open reduction (Anaes.) (Assist.) Fee: \$382.60 Benefit: 75% = \$286.95	
47054	KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.) Fee: \$287.00 Benefit: 75% = \$215.25 85% = \$243.95	
47057	PATELLA, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$112.25 Benefit: 75% = \$84.20 85% = \$95.45	
47060	PATELLA, treatment of dislocation of, by open reduction (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	
47063	ANKLE or TARSUS, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$224.60 Benefit: 75% = \$168.45 85% = \$190.95	
47066	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.) Fee: \$299.45 Benefit: 75% = \$224.60	
47069	TOE, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15	
47072	TOE, treatment of dislocation of, by open reduction (Anaes.) Fee: \$83.05 Benefit: 75% = \$62.30 85% = \$70.60	
TREATMENT OF FRACTURES <i>(Note: See paragraph T8.92 of explanatory notes to this Category)</i>		
47300	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by closed reduction, including percutaneous fixation where used (Anaes.) Fee: \$74.90 Benefit: 75% = \$56.20 85% = \$63.70	
47303	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$87.40 Benefit: 75% = \$65.55 85% = \$74.30	
47306	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by open reduction (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80	
47309	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by open reduction (Anaes.) Fee: \$124.80 Benefit: 75% = \$93.60 85% = \$106.10	
47312	MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction (Anaes.) Fee: \$112.25 Benefit: 75% = \$84.20 85% = \$95.45	
47315	MIDDLE PHALANX of FINGER, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$128.95 Benefit: 75% = \$96.75 85% = \$109.65	
47318	MIDDLE PHALANX OF FINGER, treatment of fracture of, by open reduction (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	
47321	MIDDLE PHALANX OF FINGER, treatment of intra-articular fracture of, by open reduction (Anaes.) Fee: \$187.15 Benefit: 75% = \$140.40	
47324	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	

OPERATIONS		ORTHOPAEDIC
47327	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$174.60 Benefit: 75% = \$130.95 85% = \$148.45	
47330	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by open reduction (Anaes.) Fee: \$199.70 Benefit: 75% = \$149.80 85% = \$169.75	
47333	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (Anaes.) (Assist.) Fee: \$249.50 Benefit: 75% = \$187.15	
47336	METACARPAL, treatment of fracture of, by closed reduction (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	
47339	METACARPAL, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$174.60 Benefit: 75% = \$130.95 85% = \$148.45	
47342	METACARPAL, treatment of fracture of, by open reduction (Anaes.) Fee: \$199.70 Benefit: 75% = \$149.80 85% = \$169.75	
47345	METACARPAL, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) Fee: \$249.50 Benefit: 75% = \$187.15	
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.) Fee: \$83.05 Benefit: 75% = \$62.30 85% = \$70.60	
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85	
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$332.80 Benefit: 75% = \$249.60 85% = \$282.90	
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: \$116.50 Benefit: 75% = \$87.40 85% = \$99.05	
47363	RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction (Anaes.) Fee: \$174.60 Benefit: 75% = \$130.95 85% = \$148.45	
47366	RADIUS OR ULNA, distal end of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$232.95 Benefit: 75% = \$174.75 85% = \$198.05	
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: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	
47372	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) Fee: \$249.50 Benefit: 75% = \$187.15 85% = \$212.10	
47375	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) Fee: \$332.80 Benefit: 75% = \$249.60	
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: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	
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: \$224.60 Benefit: 75% = \$168.45 85% = \$190.95	
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$299.45 Benefit: 75% = \$224.60	

OPERATIONS	ORTHOPAEDIC
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: \$257.85 Benefit: 75% = \$193.40 85% = \$219.20
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: \$415.90 Benefit: 75% = \$311.95
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: \$241.20 Benefit: 75% = \$180.90 85% = \$205.05
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: \$361.90 Benefit: 75% = \$271.45
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$482.45 Benefit: 75% = \$361.85
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes.) Fee: \$166.35 Benefit: 75% = \$124.80 85% = \$141.40
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$332.80 Benefit: 75% = \$249.60
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) Fee: \$249.50 Benefit: 75% = \$187.15 85% = \$212.10
‡ 47405	RADIUS, treatment of fracture of head or neck of, closed reduction of (Anaes.) Fee: \$166.35 Benefit: 75% = \$124.80 85% = \$141.40
‡ 47408	RADIUS, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Anaes.) (Assist.) Fee: \$332.80 Benefit: 75% = \$249.60
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80
47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.) Fee: \$199.70 Benefit: 75% = \$149.80 85% = \$169.75
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) Fee: \$232.95 Benefit: 75% = \$174.75 85% = \$198.05
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) Fee: \$457.60 Benefit: 75% = \$343.20
47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.) Fee: \$191.30 Benefit: 75% = \$143.50 85% = \$162.65
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: \$287.00 Benefit: 75% = \$215.25 85% = \$243.95
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$382.60 Benefit: 75% = \$286.95
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) Fee: \$478.35 Benefit: 75% = \$358.80
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) Fee: \$366.10 Benefit: 75% = \$274.60 85% = \$311.20
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) Fee: \$582.45 Benefit: 75% = \$436.85

OPERATIONS		ORTHOPAEDIC
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) Fee: \$727.95 Benefit: 75% = \$546.00	
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.) Fee: \$199.70 Benefit: 75% = \$149.80 85% = \$169.75	
47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$299.45 Benefit: 75% = \$224.60	
47450	HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) Fee: \$399.30 Benefit: 75% = \$299.50	
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.) Fee: \$481.40 Benefit: 75% = \$361.05	
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.) Fee: \$232.95 Benefit: 75% = \$174.75 85% = \$198.05	
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: \$349.50 Benefit: 75% = \$262.15 85% = \$297.10	
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: \$465.90 Benefit: 75% = \$349.45	
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80	
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes.) Fee: \$199.70 Benefit: 75% = \$149.80 85% = \$169.75	
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80	
47467	STERNUM, treatment of fracture of, by open reduction (Anaes.) Fee: \$199.70 Benefit: 75% = \$149.80	
47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$382.60 Benefit: 75% = \$286.95 85% = \$325.25	
47471	RIBS (1 or more), treatment of fracture of - each attendance Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30	
47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum Fee: \$166.35 Benefit: 75% = \$124.80 85% = \$141.40	
47477	PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85	
47480	PELVIC RING, treatment of fracture of, requiring traction (Anaes.) (Assist.) Fee: \$415.90 Benefit: 75% = \$311.95	
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.) Fee: \$499.10 Benefit: 75% = \$374.35	
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: \$831.95 Benefit: 75% = \$624.00	
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: \$1,247.90 Benefit: 75% = \$935.95	

OPERATIONS		ORTHOPAEDIC
47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85	
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.) Fee: \$415.90 Benefit: 75% = \$311.95 85% = \$353.55	
47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.) (Assist.) Fee: \$623.90 Benefit: 75% = \$467.95	
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: \$831.95 Benefit: 75% = \$624.00	
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: \$1,247.90 Benefit: 75% = \$935.95 85% = \$1,184.00	
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: \$1,247.90 Benefit: 75% = \$935.95	
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: \$1,247.90 Benefit: 75% = \$935.95	
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: \$332.80 Benefit: 75% = \$249.60	
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) Fee: \$382.60 Benefit: 75% = \$286.95 85% = \$325.25	
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.) Fee: \$765.40 Benefit: 75% = \$574.05	
47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20	
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.) Fee: \$765.40 Benefit: 75% = \$574.05	
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20	
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.) Fee: \$848.50 Benefit: 75% = \$636.40	
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: \$956.70 Benefit: 75% = \$717.55	
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: \$382.60 Benefit: 75% = \$286.95 85% = \$325.25	
47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes.) Fee: \$191.30 Benefit: 75% = \$143.50 85% = \$162.65	
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.) Fee: \$199.70 Benefit: 75% = \$149.80 85% = \$169.75	
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) Fee: \$299.45 Benefit: 75% = \$224.60 85% = \$254.55	
47549	TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.) Fee: \$399.30 Benefit: 75% = \$299.50	

OPERATIONS		ORTHOPAEDIC
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: \$332.80 Benefit: 75% = \$249.60 85% = \$282.90	
47555	TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.) Fee: \$499.10 Benefit: 75% = \$374.35	
47558	TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20	
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: \$241.20 Benefit: 75% = \$180.90 85% = \$205.05	
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) Fee: \$361.90 Benefit: 75% = \$271.45 85% = \$307.65	
47565	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) Fee: \$629.50 Benefit: 75% = \$472.15	
47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.) Fee: \$802.40 Benefit: 75% = \$601.80	
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) Fee: \$420.05 Benefit: 75% = \$315.05 85% = \$357.05	
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) Fee: \$482.45 Benefit: 75% = \$361.85 85% = \$418.55	
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes.) (Assist.) Fee: \$603.10 Benefit: 75% = \$452.35	
47576	FIBULA, treatment of fracture of (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80	
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.) Fee: \$141.45 Benefit: 75% = \$106.10 85% = \$120.25	
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45	
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.) Fee: \$374.45 Benefit: 75% = \$280.85	
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: \$1,164.55 Benefit: 75% = \$873.45	
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: \$1,414.40 Benefit: 75% = \$1,060.80	
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.) Fee: \$191.30 Benefit: 75% = \$143.50 85% = \$162.65	
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes.) Fee: \$287.00 Benefit: 75% = \$215.25 85% = \$243.95	
47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) Fee: \$382.60 Benefit: 75% = \$286.95	
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) Fee: \$499.10 Benefit: 75% = \$374.35	

OPERATIONS		ORTHOPAEDIC
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: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85	
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$311.95 Benefit: 75% = \$234.00 85% = \$265.20	
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$361.90 Benefit: 75% = \$271.45 85% = \$307.65	
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$415.90 Benefit: 75% = \$311.95 85% = \$353.55	
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$520.05 Benefit: 75% = \$390.05	
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$361.90 Benefit: 75% = \$271.45 85% = \$307.65	
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$499.10 Benefit: 75% = \$374.35	
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes.) Fee: \$141.45 Benefit: 75% = \$106.10 85% = \$120.25	
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$299.45 Benefit: 75% = \$224.60 85% = \$254.55	
47633	METATARSAL, 1 of, treatment of fracture of (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80	
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes.) Fee: \$199.70 Benefit: 75% = \$149.80 85% = \$169.75	
47642	METATARSALS, 2 of, treatment of fracture of (Anaes.) Fee: \$133.20 Benefit: 75% = \$99.90 85% = \$113.25	
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes.) Fee: \$199.70 Benefit: 75% = \$149.80 85% = \$169.75	
47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$266.05 Benefit: 75% = \$199.55	
47651	METATARSALS, 3 or more of, treatment of fracture of (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85	
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.) Fee: \$311.95 Benefit: 75% = \$234.00 85% = \$265.20	
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$415.90 Benefit: 75% = \$311.95	
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes.) Fee: \$124.80 Benefit: 75% = \$93.60 85% = \$106.10	
47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85	
47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80	

OPERATIONS		ORTHOPAEDIC
47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	
47681	SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30	
47684	SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, with immobilisation by calipers or halo (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20 85% = \$601.70	
47687	SPINE, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, with immobilisation by calipers or halo, and including up to 14 days post-operative care (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45	
47690	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation (Anaes.) (Assist.) Fee: \$915.05 Benefit: 75% = \$686.30	
47693	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation, including up to 14 days post-operative care (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45	
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: \$332.80 Benefit: 75% = \$249.60 85% = \$282.90	
47699	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (Anaes.) (Assist.) Fee: \$1,331.10 Benefit: 75% = \$998.35	
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: \$1,663.85 Benefit: 75% = \$1,247.90	
47703	SKULL, treatment of fracture of, each attendance Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30	
47705	SKULL CALIPERS, insertion of, as an independent procedure (Anaes.) (Assist.) Fee: \$249.50 Benefit: 75% = \$187.15	
47708	PLASTER JACKET, application of, as an independent procedure (Anaes.) Fee: \$191.30 Benefit: 75% = \$143.50 85% = \$162.65	
47711	HALO, application of, as an independent procedure (Anaes.) (Assist.) Fee: \$282.95 Benefit: 75% = \$212.25	
47714	HALO, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) Fee: \$212.10 Benefit: 75% = \$159.10	
47717	HALO-THORACIC TRACTION - application of both halo and thoracic jacket (Anaes.) (Assist.) Fee: \$374.45 Benefit: 75% = \$280.85	
47720	HALO-FEMORAL TRACTION, as an independent procedure (Anaes.) (Assist.) Fee: \$374.45 Benefit: 75% = \$280.85 85% = \$318.30	
47723	HALO-FEMORAL TRACTION, in conjunction with a major spine operation (Anaes.) (Assist.) Fee: \$374.45 Benefit: 75% = \$280.85 85% = \$318.30	
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.) Fee: \$124.80 Benefit: 75% = \$93.60	
47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05	
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (Anaes.) (Assist.) Fee: \$332.80 Benefit: 75% = \$249.60	

OPERATIONS	ORTHOPAEDIC
47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30
47738	NASAL BONES, treatment of fracture of, by reduction (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.) Fee: \$424.45 Benefit: 75% = \$318.35
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) Fee: \$359.35 Benefit: 75% = \$269.55
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) Fee: \$359.35 Benefit: 75% = \$269.55
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) Fee: \$211.05 Benefit: 75% = \$158.30 85% = \$179.40
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) Fee: \$346.50 Benefit: 75% = \$259.90
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) Fee: \$424.45 Benefit: 75% = \$318.35
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) Fee: \$487.60 Benefit: 75% = \$365.70
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.) Fee: \$385.00 Benefit: 75% = \$288.75
47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) Fee: \$385.00 Benefit: 75% = \$288.75
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) Fee: \$500.45 Benefit: 75% = \$375.35
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) Fee: \$500.45 Benefit: 75% = \$375.35 85% = \$436.55
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) Fee: \$635.10 Benefit: 75% = \$476.35
47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) Fee: \$635.10 Benefit: 75% = \$476.35
	GENERAL
47900	BONE CYST, injection into or aspiration of (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35
47903	EPICONDYLITIS, open operation for (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.) Fee: \$49.95 Benefit: 75% = \$37.50 85% = \$42.50
47906	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80
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: \$49.95 Benefit: 75% = \$37.50 85% = \$42.50

OPERATIONS		ORTHOPAEDIC
47915	INGROWING NAIL OF TOE, wedge resection for, including removal of segment of nail, unguual fold and portion of the nail bed (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35	
47916	INGROWING NAIL OF TOE, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) Fee: \$75.25 Benefit: 75% = \$56.45 85% = \$64.00	
47918	INGROWING TOENAIL, radical excision of nailbed (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85	
47920	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) Fee: \$336.45 Benefit: 75% = \$252.35	
47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80	
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: \$33.25 Benefit: 75% = \$24.95 85% = \$28.30	
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: \$124.80 Benefit: 75% = \$93.60	
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, <u>removal of</u> , not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.) Fee: \$232.95 Benefit: 75% = \$174.75	
47933	EXOSTOSIS OF SMALL BONE, excision of, including simple removal of bunion and any associated bursa (Anaes.) Fee: \$182.95 Benefit: 75% = \$137.25 85% = \$155.55	
47936	EXOSTOSIS OF LARGE BONE, excision of (Anaes.) (Assist.) Fee: \$224.60 Benefit: 75% = \$168.45	
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$141.45 Benefit: 75% = \$106.10	
47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) Fee: \$166.35 Benefit: 75% = \$124.80 85% = \$141.40	
47954	TENDON, repair of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$332.80 Benefit: 75% = \$249.60 85% = \$282.90	
47957	TENDON, large, lengthening of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$249.50 Benefit: 75% = \$187.15	
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) Fee: \$116.50 Benefit: 75% = \$87.40 85% = \$99.05	
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.) Fee: \$191.30 Benefit: 75% = \$143.50 85% = \$162.65	
47966	TENDON OR LIGAMENT, TRANSFER, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$382.60 Benefit: 75% = \$286.95	
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$232.95 Benefit: 75% = \$174.75	
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.) Fee: \$186.10 Benefit: 75% = \$139.60	
47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.) Fee: \$326.15 Benefit: 75% = \$244.65	

OPERATIONS	ORTHOPAEDIC
47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) Fee: \$198.15 Benefit: 75% = \$148.65
47981	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes.) Fee: \$133.00 Benefit: 75% = \$99.75 85% = \$113.05
47982	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.) Fee: \$322.45 Benefit: 75% = \$241.85
BONE GRAFTS	
48200	FEMUR, bone graft to (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20
48203	FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.) Fee: \$807.00 Benefit: 75% = \$605.25
48206	TIBIA, bone graft to (Anaes.) (Assist.) Fee: \$499.65 Benefit: 75% = \$374.75
48209	TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.) Fee: \$640.60 Benefit: 75% = \$480.45
48212	HUMERUS, bone graft to (Anaes.) (Assist.) Fee: \$499.65 Benefit: 75% = \$374.75
48215	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.) Fee: \$640.60 Benefit: 75% = \$480.45
48218	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.) Fee: \$499.65 Benefit: 75% = \$374.75
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20
48224	RADIUS OR ULNA, bone graft to (Anaes.) (Assist.) Fee: \$332.80 Benefit: 75% = \$249.60
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) Fee: \$432.60 Benefit: 75% = \$324.45
48230	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.) Fee: \$374.45 Benefit: 75% = \$280.85
48233	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.) Fee: \$540.75 Benefit: 75% = \$405.60
48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.) Fee: \$707.15 Benefit: 75% = \$530.40
48239	BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$390.95 Benefit: 75% = \$293.25
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$540.75 Benefit: 75% = \$405.60
OSTEOTOMY OR OSTECTOMY	
48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$457.60 Benefit: 75% = \$343.20

OPERATIONS		ORTHOPAEDIC
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45	
48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$457.60 Benefit: 75% = \$343.20	
48412	HUMERUS, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$557.25 Benefit: 75% = \$417.95	
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$707.15 Benefit: 75% = \$530.40	
48418	TIBIA, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$557.25 Benefit: 75% = \$417.95 85% = \$493.35	
48421	TIBIA, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$707.15 Benefit: 75% = \$530.40	
48424	FEMUR OR PELVIS, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20	
48427	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$807.00 Benefit: 75% = \$605.25	
EPIPHYSIODESIS		
48500	FEMUR, epiphysiodesis of (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45	
48503	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45	
48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) Fee: \$432.60 Benefit: 75% = \$324.45	
48509	EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05	
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.) Fee: \$790.30 Benefit: 75% = \$592.75	
SPINE		
48600	SPINE, MANIPULATION OF, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$83.05 Benefit: 75% = \$62.30	
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: \$124.80 Benefit: 75% = \$93.60 85% = \$106.10	
48606	SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (Anaes.) (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45	
48612	SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Anaes.) (Assist.) Fee: \$2,163.00 Benefit: 75% = \$1,622.25	
48613	SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) Fee: \$3,076.65 Benefit: 75% = \$2,307.50	
48615	SCOLIOSIS, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Anaes.) (Assist.) Fee: \$390.95 Benefit: 75% = \$293.25	

OPERATIONS		ORTHOPAEDIC
48618	SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Anaes.) (Assist.) Fee: \$2,163.00 Benefit: 75% = \$1,622.25	
48621	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Anaes.) (Assist.) Fee: \$1,414.40 Benefit: 75% = \$1,060.80	
48624	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) Fee: \$1,747.15 Benefit: 75% = \$1,310.40	
48627	SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Anaes.) (Assist.) Fee: \$2,246.10 Benefit: 75% = \$1,684.60	
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: \$2,495.75 Benefit: 75% = \$1,871.85	
48632	SCOLIOSIS, congenital, vertebral resection and fusion for (Anaes.) (Assist.) Fee: \$1,379.60 Benefit: 75% = \$1,034.70	
‡ 48636	PERCUTANEOUS LUMBAR PARTIAL OR TOTAL DISCECTOMY, 1 or more levels, not being a service associated with intradiscal electrothermal annuloplasty (Anaes.) (Assist.) <i>(See para T8.113 of explanatory notes to this Category)</i> Fee: \$715.35 Benefit: 75% = \$536.55 85% = \$651.45	
48639	VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixation (Anaes.) (Assist.) Fee: \$1,206.20 Benefit: 75% = \$904.65	
48640	VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) Fee: \$3,076.65 Benefit: 75% = \$2,307.50	
48642	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Anaes.) (Assist.) Fee: \$707.15 Benefit: 75% = \$530.40	
48645	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Anaes.) (Assist.) Fee: \$956.70 Benefit: 75% = \$717.55	
48648	SPINE, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Anaes.) (Assist.) Fee: \$956.70 Benefit: 75% = \$717.55	
48651	SPINE, bone graft to, (postero-lateral fusion) - more than 2 levels (Anaes.) (Assist.) Fee: \$1,331.10 Benefit: 75% = \$998.35	
‡ 48654	SPINAL FUSION (posterior interbody), with partial or total laminectomy, 1 level (Anaes.) (Assist.) Fee: \$956.70 Benefit: 75% = \$717.55	
‡ 48657	SPINAL FUSION (posterior interbody), with partial or total laminectomy, more than 1 level (Anaes.) (Assist.) Fee: \$1,331.10 Benefit: 75% = \$998.35	
‡ 48660	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level, not being a service associated with artificial intervertebral total disc replacement (Anaes.) (Assist.) <i>(See para T8.114 of explanatory notes to this Category)</i> Fee: \$956.70 Benefit: 75% = \$717.55	
48663	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.) <i>(See para T8.114 of explanatory notes to this Category)</i> Fee: \$715.35 Benefit: 75% = \$536.55	
48666	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) <i>(See para T8.114 of explanatory notes to this Category)</i> Fee: \$432.60 Benefit: 75% = \$324.45	

OPERATIONS		ORTHOPAEDIC
‡ 48669	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level, not being a service associated with artificial intervertebral total disc replacement (Anaes.) (Assist.) (See para T8.114 of explanatory notes to this Category) Fee: \$1,289.45 Benefit: 75% = \$967.10	
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.) (See para T8.114 of explanatory notes to this Category) Fee: \$965.15 Benefit: 75% = \$723.90	
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.) (See para T8.114 of explanatory notes to this Category) Fee: \$582.45 Benefit: 75% = \$436.85	
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 T8.115 of explanatory notes to this Category) Fee: \$499.65 Benefit: 75% = \$374.75	
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 T8.115 of explanatory notes to this Category) Fee: \$831.95 Benefit: 75% = \$624.00	
‡ 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, not being a service associated with artificial intervertebral total disc replacement (Anaes.) (Assist.) (See para T8.115 of explanatory notes to this Category) Fee: \$831.95 Benefit: 75% = \$624.00	
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 T8.115 of explanatory notes to this Category) Fee: \$1,164.55 Benefit: 75% = \$873.45	
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 T8.115 of explanatory notes to this Category) Fee: \$1,331.10 Benefit: 75% = \$998.35	
† 48691	LUMBAR ARTIFICIAL INTERVERTEBRAL TOTAL DISC REPLACEMENT including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, with fluoroscopy (Anaes.) (Assist.) (See para T8.116 of explanatory notes to this Category) Fee: \$1,585.00 Benefit: 75% = \$1,188.75 85% = \$1,521.10	
† 48692	LUMBAR ARTIFICIAL INTERVERTEBRAL TOTAL DISC REPLACEMENT including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, with fluoroscopy (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.) (See para T8.116 of explanatory notes to this Category) Fee: \$1,068.30 Benefit: 75% = \$801.25 85% = \$1,004.40	
† 48693	LUMBAR ARTIFICIAL INTERVERTEBRAL TOTAL DISC REPLACEMENT including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, (where an assisting surgeon performs the approach) - assisting surgeon (Anaes.) (Assist.) (See para T8.116 of explanatory notes to this Category) Fee: \$516.70 Benefit: 75% = \$387.55 85% = \$452.80	
	SHOULDER	
48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.) Fee: \$249.50 Benefit: 75% = \$187.15 85% = \$212.10	

OPERATIONS	ORTHOPAEDIC
48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.) Fee: \$499.10 Benefit: 75% = \$374.35
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: \$499.10 Benefit: 75% = \$374.35
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: \$665.60 Benefit: 75% = \$499.20
48912	SHOULDER, arthroscopy of (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45 85% = \$247.60
48915	SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.) Fee: \$1,331.10 Benefit: 75% = \$998.35
48921	SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.) Fee: \$1,372.65 Benefit: 75% = \$1,029.50
48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.) Fee: \$1,580.70 Benefit: 75% = \$1,185.55
48927	SHOULDER prosthesis, removal of (Anaes.) (Assist.) Fee: \$324.35 Benefit: 75% = \$243.30
48930	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20
48933	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.) Fee: \$873.55 Benefit: 75% = \$655.20
48936	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20
48939	SHOULDER, arthrodesis of (Anaes.) (Assist.) Fee: \$956.70 Benefit: 75% = \$717.55
48942	SHOULDER, arthrodesis of, including removal of prosthesis, requiring bone grafting or internal fixation (Anaes.) (Assist.) Fee: \$1,247.90 Benefit: 75% = \$935.95
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) Fee: \$241.20 Benefit: 75% = \$180.90
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: \$540.75 Benefit: 75% = \$405.60
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: \$790.30 Benefit: 75% = \$592.75
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: \$831.95 Benefit: 75% = \$624.00
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: \$956.70 Benefit: 75% = \$717.55

OPERATIONS	ORTHOPAEDIC
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: \$831.95 Benefit: 75% = \$624.00
	ELBOW
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45
49103	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.) Fee: \$623.90 Benefit: 75% = \$467.95
49106	ELBOW, arthrodesis of (Anaes.) (Assist.) Fee: \$831.95 Benefit: 75% = \$624.00 85% = \$768.05
49109	ELBOW, total synovectomy of (Anaes.) (Assist.) Fee: \$623.90 Benefit: 75% = \$467.95
49112	ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.) Fee: \$623.90 Benefit: 75% = \$467.95
49115	ELBOW, total joint replacement of (Anaes.) (Assist.) Fee: \$998.25 Benefit: 75% = \$748.70
† 49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,317.65 Benefit: 75% = \$988.25
† 49117	ELBOW, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis Fee: \$1,581.15 Benefit: 75% = \$1,185.90
49118	ELBOW, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) Fee: \$241.20 Benefit: 75% = \$180.90
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: \$540.75 Benefit: 75% = \$405.60
	WRIST
49200	WRIST, arthrodesis of, including bone graft, with or without internal fixation of the radiocarpal joint (Anaes.) (Assist.) <i>(See para T8.117 of explanatory notes to this Category)</i> Fee: \$723.70 Benefit: 75% = \$542.80
49203	WRIST, limited arthrodesis of the intercarpal joint, including bone graft (Anaes.) (Assist.) <i>(See para T8.117 of explanatory notes to this Category)</i> Fee: \$540.75 Benefit: 75% = \$405.60
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.) <i>(See para T8.117 of explanatory notes to this Category)</i> Fee: \$499.10 Benefit: 75% = \$374.35
49209	WRIST, total replacement arthroplasty of (Anaes.) (Assist.) <i>(See para T8.117 of explanatory notes to this Category)</i> Fee: \$665.60 Benefit: 75% = \$499.20
† 49210	WRIST, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) Fee: \$878.55 Benefit: 75% = \$658.95
† 49211	WRIST, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,054.30 Benefit: 75% = \$790.75
49212	WRIST, arthrotomy of (Anaes.) <i>(See para T8.117 of explanatory notes to this Category)</i> Fee: \$208.05 Benefit: 75% = \$156.05

OPERATIONS		ORTHOPAEDIC
49215	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.) (Assist.) (See para T8.117 of explanatory notes to this Category) Fee: \$574.10 Benefit: 75% = \$430.60	
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 T8.117 of explanatory notes to this Category) Fee: \$241.20 Benefit: 75% = \$180.90	
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 T8.117 of explanatory notes to this Category) Fee: \$540.75 Benefit: 75% = \$405.60	
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 T8.117 of explanatory notes to this Category) Fee: \$623.90 Benefit: 75% = \$467.95	
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 T8.117 of explanatory notes to this Category) Fee: \$623.90 Benefit: 75% = \$467.95	
	HIP	
49300	SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45	
49303	HIP, arthrotomy of, including lavage, drainage or biopsy when performed (Anaes.) (Assist.) Fee: \$482.45 Benefit: 75% = \$361.85	
49306	HIP arthrodesis of (Anaes.) (Assist.) Fee: \$956.70 Benefit: 75% = \$717.55	
49309	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20	
49312	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.) Fee: \$831.95 Benefit: 75% = \$624.00	
49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.) Fee: \$748.80 Benefit: 75% = \$561.60	
49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45	
49319	HIP, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) Fee: \$2,045.90 Benefit: 75% = \$1,534.45	
49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,414.40 Benefit: 75% = \$1,060.80	
49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,663.85 Benefit: 75% = \$1,247.90	
49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,913.40 Benefit: 75% = \$1,435.05	
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,913.40 Benefit: 75% = \$1,435.05	

OPERATIONS	ORTHOPAEDIC
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.) Fee: \$2,163.00 Benefit: 75% = \$1,622.25
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: \$316.05 Benefit: 75% = \$237.05
49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.) Fee: \$2,454.10 Benefit: 75% = \$1,840.60
49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.) Fee: \$2,454.10 Benefit: 75% = \$1,840.60
49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.) Fee: \$2,911.70 Benefit: 75% = \$2,183.80
49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.) Fee: \$748.80 Benefit: 75% = \$561.60
49360	HIP, diagnostic arthroscopy of (Anaes.) (Assist.) Fee: \$303.95 Benefit: 75% = \$228.00
49363	HIP, diagnostic arthroscopy of, with synovial biopsy (Anaes.) (Assist.) Fee: \$366.05 Benefit: 75% = \$274.55 85% = \$311.15
49366	HIP, arthroscopic surgery of (Anaes.) (Assist.) Fee: \$540.75 Benefit: 75% = \$405.60
	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: \$332.80 Benefit: 75% = \$249.60
‡ 49503	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon or any other single procedure (not being a service to which another item in this Groups applies) – any 1 procedure (Anaes.) (Assist.) Fee: \$432.60 Benefit: 75% = \$324.45
‡ 49506	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon or any other single procedure (not being a service to which another item in this Groups applies) – any 2 or more procedures (Anaes.) (Assist.) (Anaes.) (Assist.) Fee: \$648.90 Benefit: 75% = \$486.70
49509	KNEE, total synovectomy or arthrodesis of (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20
49512	KNEE, arthrodesis of, with removal of prosthesis (Anaes.) (Assist.) Fee: \$956.70 Benefit: 75% = \$717.55
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.) Fee: \$748.80 Benefit: 75% = \$561.60
49517	KNEE, hemiarthroplasty of (Anaes.) (Assist.) Fee: \$1,066.00 Benefit: 75% = \$799.50
49518	KNEE, total replacement arthroplasty of (Anaes.) (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45
49519	KNEE, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) Fee: \$2,045.90 Benefit: 75% = \$1,534.45

OPERATIONS		ORTHOPAEDIC
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,414.40 Benefit: 75% = \$1,060.80	
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,663.85 Benefit: 75% = \$1,247.90	
49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,414.40 Benefit: 75% = \$1,060.80	
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: \$1,747.15 Benefit: 75% = \$1,310.40	
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: \$1,996.65 Benefit: 75% = \$1,497.50	
49534	KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.) Fee: \$397.15 Benefit: 75% = \$297.90	
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: \$831.95 Benefit: 75% = \$624.00	
‡ 49539	KNEE, reconstructive surgery of cruciate ligament or 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: \$831.95 Benefit: 75% = \$624.00	
‡ 49542	KNEE, reconstructive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed (Anaes.) (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45	
49545	KNEE, revision arthrodesis of (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20	
49548	KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.) Fee: \$831.95 Benefit: 75% = \$624.00	
49551	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45	
49554	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.) Fee: \$1,663.85 Benefit: 75% = \$1,247.90	
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: \$241.20 Benefit: 75% = \$180.90	
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: \$241.20 Benefit: 75% = \$180.90	
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: \$361.15 Benefit: 75% = \$270.90	
‡ 49560	KNEE, arthroscopic surgery of, involving 1 or more of: partial or total 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: \$487.45 Benefit: 75% = \$365.60	

OPERATIONS		ORTHOPAEDIC
‡ 49561	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty – not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) Fee: \$595.65 Benefit: 75% = \$446.75	
‡ 49562	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total 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: \$649.90 Benefit: 75% = \$487.45	
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: \$703.95 Benefit: 75% = \$528.00	
49564	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer (Anaes.) (Assist.) Fee: \$812.05 Benefit: 75% = \$609.05	
49566	KNEE, arthroscopic total synovectomy of (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20	
49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20	
	ANKLE	
49700	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) Fee: \$241.20 Benefit: 75% = \$180.90	
49703	ANKLE, arthroscopic surgery of (Anaes.) (Assist.) Fee: \$540.75 Benefit: 75% = \$405.60	
49706	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45	
49709	ANKLE, ligamentous stabilisation of (Anaes.) (Assist.) Fee: \$623.90 Benefit: 75% = \$467.95	
49712	ANKLE, arthrodesis of (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20	
49715	ANKLE, total joint replacement of (Anaes.) (Assist.) Fee: \$998.25 Benefit: 75% = \$748.70	
† 49716	ANKLE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,317.65 Benefit: 75% = \$988.25	
† 49717	ANKLE, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,581.15 Benefit: 75% = \$1,185.90	
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.) Fee: \$332.80 Benefit: 75% = \$249.60	
49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85	
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.) Fee: \$582.45 Benefit: 75% = \$436.85	
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.) Fee: \$249.50 Benefit: 75% = \$187.15	
† 49728	ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.) Fee: \$498.95 Benefit: 75% = \$374.25	

OPERATIONS		ORTHOPAEDIC	
		FOOT	
49800	FOOT, flexor or extensor tendon, primary repair of (Anaes.) Fee: \$116.50 Benefit: 75% = \$87.40 85% = \$99.05		
49803	FOOT, flexor or extensor tendon, secondary repair of (Anaes.) Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35		
49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes.) Fee: \$116.50 Benefit: 75% = \$87.40 85% = \$99.05		
49809	FOOT, open tenotomy of, with or without tenoplasty (Anaes.) Fee: \$191.30 Benefit: 75% = \$143.50		
49812	FOOT, tendon or ligament transplplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$382.60 Benefit: 75% = \$286.95		
49815	FOOT, triple arthrodesis of (Anaes.) (Assist.) Fee: \$665.60 Benefit: 75% = \$499.20		
49818	FOOT, excision of calcaneal spur (Anaes.) (Assist.) Fee: \$241.20 Benefit: 75% = \$180.90		
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.) (Assist.) Fee: \$382.60 Benefit: 75% = \$286.95		
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.) (Assist.) Fee: \$669.70 Benefit: 75% = \$502.30		
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.) Fee: \$415.90 Benefit: 75% = \$311.95		
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.) Fee: \$727.95 Benefit: 75% = \$546.00		
49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - unilateral (Anaes.) (Assist.) Fee: \$457.60 Benefit: 75% = \$343.20		
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - bilateral (Anaes.) (Assist.) Fee: \$790.30 Benefit: 75% = \$592.75		
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: \$571.95 Benefit: 75% = \$429.00		
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: \$987.70 Benefit: 75% = \$740.80		
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.) (Assist.) Fee: \$457.60 Benefit: 75% = \$343.20		
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.) (Assist.) Fee: \$790.30 Benefit: 75% = \$592.75		
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint (Anaes.) (Assist.) Fee: \$415.90 Benefit: 75% = \$311.95		
49848	FOOT, correction of claw or hammer toe (Anaes.) Fee: \$141.45 Benefit: 75% = \$106.10 85% = \$120.25		
49851	FOOT, correction of claw or hammer toe with internal fixation (Anaes.) Fee: \$182.95 Benefit: 75% = \$137.25		

OPERATIONS	ORTHOPAEDIC
49854	FOOT, radical plantar fasciotomy or fasciectomy of (Anaes.) (Assist.) Fee: \$332.80 Benefit: 75% = \$249.60
49857	FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.) Fee: \$307.80 Benefit: 75% = \$230.85
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.) Fee: \$249.50 Benefit: 75% = \$187.15
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.) Fee: \$374.45 Benefit: 75% = \$280.85
49866	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.) Fee: \$266.05 Benefit: 75% = \$199.55
49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation - each attendance (Anaes.) Fee: \$49.95 Benefit: 75% = \$37.50 85% = \$42.50
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: \$241.20 Benefit: 75% = \$180.90 85% = \$205.05
50102	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$540.75 Benefit: 75% = \$405.60
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$276.00 Benefit: 75% = \$207.00 85% = \$234.60
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: \$415.90 Benefit: 75% = \$311.95
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$415.90 Benefit: 75% = \$311.95
50112	CICATRICAL 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: \$319.05 Benefit: 75% = \$239.30
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: \$124.80 Benefit: 75% = \$93.60 85% = \$106.10
50118	SUBTALAR JOINT, arthrodesis of (Anaes.) (Assist.) Fee: \$382.60 Benefit: 75% = \$286.95
50121	GREATER TROCHANTER, transplplantation of ileopsoas tendon to (Anaes.) (Assist.) Fee: \$748.80 Benefit: 75% = \$561.60
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.) <i>(See para T8.118 of explanatory notes to this Category)</i> Fee: \$26.15 Benefit: 75% = \$19.65 85% = \$22.25
50125	JOINT OR OTHER SYNOVIAL CAVITY, aspiration of, or injection into, or both of these procedures - <i>where it can be demonstrated that a 26th or subsequent treatment (including any treatments to which item 50124 applies) is indicated in a 12 month period</i> (Anaes.) <i>(See para T8.118 of explanatory notes to this Category)</i> Fee: \$26.15 Benefit: 75% = \$19.65 85% = \$22.25

OPERATIONS	ORTHOPAEDIC
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.) Fee: \$620.75 Benefit: 75% = \$465.60
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) Fee: \$276.00 Benefit: 75% = \$207.00
MALIGNANT DISEASE	
50200	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) Fee: \$166.35 Benefit: 75% = \$124.80 85% = \$141.40
50201	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.) Fee: \$291.15 Benefit: 75% = \$218.40
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) Fee: \$366.10 Benefit: 75% = \$274.60 85% = \$311.20
50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) Fee: \$540.75 Benefit: 75% = \$405.60
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: \$665.60 Benefit: 75% = \$499.20
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: \$1,455.85 Benefit: 75% = \$1,091.90
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: \$1,830.25 Benefit: 75% = \$1,372.70
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint (Anaes.) (Assist.) Fee: \$2,412.60 Benefit: 75% = \$1,809.45
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.) Fee: \$2,246.10 Benefit: 75% = \$1,684.60
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: \$2,495.75 Benefit: 75% = \$1,871.85 85% = \$2,431.85
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.) Fee: \$2,911.70 Benefit: 75% = \$2,183.80
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.) Fee: \$1,497.40 Benefit: 75% = \$1,123.05
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.) Fee: \$1,913.40 Benefit: 75% = \$1,435.05
50236	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.) Fee: \$1,497.40 Benefit: 75% = \$1,123.05
50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$998.25 Benefit: 75% = \$748.70

OPERATIONS	ORTHOPAEDIC
	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: \$1,022.95 Benefit: 75% = \$767.25
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: \$1,396.65 Benefit: 75% = \$1,047.50
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: \$2,180.70 Benefit: 75% = \$1,635.55 85% = \$2,116.80
50309	RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility, not being a service to which item 50303 or 50306 applies (Anaes.) (Assist.) Fee: \$269.50 Benefit: 75% = \$202.15
50312	ANKLE, synovectomy of (Anaes.) (Assist.) Fee: \$618.65 Benefit: 75% = \$464.00
50315	TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.) Fee: \$612.55 Benefit: 75% = \$459.45
50318	TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.) Fee: \$612.55 Benefit: 75% = \$459.45
50321	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.) Fee: \$820.80 Benefit: 75% = \$615.60
50324	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.) Fee: \$1,170.00 Benefit: 75% = \$877.50
50327	TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.) Fee: \$1,427.20 Benefit: 75% = \$1,070.40
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: \$202.10 Benefit: 75% = \$151.60 85% = \$171.80
50333	TARSAL COALITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.) (Assist.) Fee: \$545.10 Benefit: 75% = \$408.85
50336	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.) (Assist.) Fee: \$814.75 Benefit: 75% = \$611.10
50339	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.) (Assist.) Fee: \$496.25 Benefit: 75% = \$372.20
50342	FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.) (Assist.) Fee: \$575.75 Benefit: 75% = \$431.85
50345	HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.) (Assist.) Fee: \$306.35 Benefit: 75% = \$229.80
	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: \$202.10 Benefit: 75% = \$151.60 85% = \$171.80

OPERATIONS		ORTHOPAEDIC
50349	HIP, congenital dislocation of, treatment of, by closed reduction (Anaes.) Fee: \$282.95 Benefit: 75% = \$212.25 85% = \$240.55	
50351	HIP, developmental dislocation of, open reduction of (Anaes.) (Assist.) Fee: \$1,411.35 Benefit: 75% = \$1,058.55 85% = \$1,347.45	
50352	HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.) Fee: \$49.95 Benefit: 75% = \$37.50 85% = \$42.50	
50353	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.) (Assist.) Fee: \$313.50 Benefit: 75% = \$235.15	
50354	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.) Fee: \$1,157.70 Benefit: 75% = \$868.30 85% = \$1,093.80	
50357	KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes.) (Assist.) Fee: \$496.25 Benefit: 75% = \$372.20	
50360	KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.) Fee: \$575.75 Benefit: 75% = \$431.85	
50363	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes.) (Assist.) Fee: \$441.00 Benefit: 75% = \$330.75	
50366	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.) (Assist.) Fee: \$771.80 Benefit: 75% = \$578.85	
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: \$575.75 Benefit: 75% = \$431.85	
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: \$1,010.70 Benefit: 75% = \$758.05	
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: \$441.00 Benefit: 75% = \$330.75	
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: \$771.80 Benefit: 75% = \$578.85	
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: \$575.75 Benefit: 75% = \$431.85	
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: \$1,010.70 Benefit: 75% = \$758.05	
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: \$575.75 Benefit: 75% = \$431.85	
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: \$202.10 Benefit: 75% = \$151.60 85% = \$171.80	
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.) Fee: \$747.25 Benefit: 75% = \$560.45	
50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.) Fee: \$2,454.10 Benefit: 75% = \$1,840.60	

OPERATIONS		ORTHOPAEDIC
	SHOULDER, ARM AND FOREARM PROCEDURES	
50396	HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.) (Assist.) Fee: \$410.50 Benefit: 75% = \$307.90	
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.) Fee: \$814.75 Benefit: 75% = \$611.10	
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.) Fee: \$373.70 Benefit: 75% = \$280.30	
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.) Fee: \$508.40 Benefit: 75% = \$381.30	
50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.) Fee: \$882.10 Benefit: 75% = \$661.60	
	AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES	
50411	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.) Fee: \$1,157.70 Benefit: 75% = \$868.30 85% = \$1,093.80	
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: \$1,562.00 Benefit: 75% = \$1,171.50 85% = \$1,498.10	
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: \$1,157.70 Benefit: 75% = \$868.30 85% = \$1,093.80	
50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.) Fee: \$955.55 Benefit: 75% = \$716.70	
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) Fee: \$882.10 Benefit: 75% = \$661.60 85% = \$818.20	
	TUMOROUS CONDITIONS	
50426	DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.) Fee: \$410.50 Benefit: 75% = \$307.90	
	SINGLE EVENT MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY	
	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following:	
	(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.	
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of femoral torsion by rotational osteotomy of the femur.	
	(d) Correction of tibial torsion by rotational osteotomy of the tibia.	
	(e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis or os calcis lengthening.	
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)	
† 50450	Fee: \$1,084.15 Benefit: 75% = \$813.15	

OPERATIONS	ORTHOPAEDIC
† 50451	<p>UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following:</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>(c) Correction of femoral torsion by rotational osteotomy of the femur.</p> <p>(d) Correction of tibial torsion by rotational osteotomy of the tibia.</p> <p>(e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis or os calcis lengthening.</p> <p>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$1,084.15 Benefit: 75% = \$813.15</p>
† 50455	<p>BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises:</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$1,227.75 Benefit: 75% = \$920.85</p>
† 50456	<p>BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises:</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$1,227.75 Benefit: 75% = \$920.85</p>
† 50460	<p>BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies.</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>(c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation.</p> <p>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$1,833.00 Benefit: 75% = \$1,374.75</p>
† 50461	<p>BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies.</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>(c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation.</p> <p>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$1,833.00 Benefit: 75% = \$1,374.75</p>
† 50465	<p>BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>(c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.</p> <p>(d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.</p> <p>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$2,581.80 Benefit: 75% = \$1,936.35</p>

OPERATIONS	ORTHOPAEDIC
† 50466	<p>BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>(c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.</p> <p>(d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.</p> <p>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$2,581.80 Benefit: 75% = \$1,936.35</p>
† 50470	<p>BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation.</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>(c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.</p> <p>(d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.</p> <p>(e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion.</p> <p>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$3,274.35 Benefit: 75% = \$2,455.80</p>
† 50471	<p>BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation.</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>(c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.</p> <p>(d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.</p> <p>(e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion.</p> <p>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$3,274.35 Benefit: 75% = \$2,455.80</p>
† 50475	<p>SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including:</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>(c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation.</p> <p>(d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction.</p> <p>(e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation.</p> <p>(f) Correction of foot instability by os calcis lengthening or subtalar fusion.</p> <p>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$3,778.30 Benefit: 75% = \$2,833.75</p>
† 50476	<p>SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including:</p> <p>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.</p> <p>(b) Correction of muscle imbalance by tendon transfer/transfers.</p> <p>(c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation.</p> <p>(d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction.</p> <p>(e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation.</p> <p>(f) Correction of foot instability by os calcis lengthening or subtalar fusion.</p> <p>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category)</p> <p>Fee: \$3,778.30 Benefit: 75% = \$2,833.75</p>
† 50500	<p style="text-align: center;">TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS</p> <p>RADIUS OR ULNA, distal end of, with open growth plate, treatment of fracture of, by closed reduction (Anaes.) (See para T8.119 and T8.120 of explanatory notes to this Category)</p> <p>Fee: \$244.45 Benefit: 75% = \$183.35 85% = \$207.80</p>

OPERATIONS		ORTHOPAEDIC
† 50504	RADIUS OR ULNA, distal end of, with open growth plate , treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$326.10 Benefit: 75% = \$244.60 85% = \$277.20	
† 50508	RADIUS, distal end of, with open growth plate , treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$349.30 Benefit: 75% = \$262.00 85% = \$296.95	
† 50512	RADIUS, distal end of, with open growth plate , treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$465.95 Benefit: 75% = \$349.50	
† 50516	RADIUS OR ULNA, shaft of, with open growth plate , treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$314.45 Benefit: 75% = \$235.85 85% = \$267.30	
† 50520	RADIUS OR ULNA, shaft of, with open growth plate , treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$419.20 Benefit: 75% = \$314.40	
† 50524	RADIUS OR ULNA, shaft of, with open growth plate , 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.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$360.95 Benefit: 75% = \$270.75 85% = \$306.85	
† 50528	RADIUS OR ULNA, shaft of, with open growth plate , treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$582.30 Benefit: 75% = \$436.75	
† 50532	RADIUS AND ULNA, shafts of, with open growth plates , treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$506.65 Benefit: 75% = \$380.00	
† 50536	RADIUS AND ULNA, shafts of, with open growth plates , treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$675.45 Benefit: 75% = \$506.60	
† 50540	OLECRANON, with open growth plate , treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$465.95 Benefit: 75% = \$349.50	
† 50544	RADIUS, with open growth plate , treatment of fracture of head or neck of, by closed reduction of (Anaes.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$232.95 Benefit: 75% = \$174.75 85% = \$198.05	
† 50548	RADIUS, with open growth plate , treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$465.95 Benefit: 75% = \$349.50	
† 50552	HUMERUS, proximal, with open growth plate , treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital or approved day-hospital facility (Anaes.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$401.80 Benefit: 75% = \$301.35 85% = \$341.55	
† 50556	HUMERUS, proximal, with open growth plate , treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$535.65 Benefit: 75% = \$401.75	

OPERATIONS	ORTHOPAEDIC
† 50560	HUMERUS, shaft of, with open growth plate , treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital or approved day-hospital facility (Anaes.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$419.20 Benefit: 75% = \$314.40
† 50564	HUMERUS, shaft of, with open growth plate , treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$559.05 Benefit: 75% = \$419.30
† 50568	HUMERUS, with open growth plate , supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$489.25 Benefit: 75% = \$366.95 85% = \$425.35
† 50572	HUMERUS, with open growth plate , supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$652.20 Benefit: 75% = \$489.15
† 50576	FEMUR, with open growth plate , treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$535.65 Benefit: 75% = \$401.75 85% = \$471.75
† 50580	TIBIA, with open growth plate , plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$559.05 Benefit: 75% = \$419.30
† 50584	TIBIA, distal, with open growth plate , treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$535.65 Benefit: 75% = \$401.75
† 50588	TIBIA AND FIBULA, with open growth plates , treatment of fracture of, by internal fixation (Anaes.) (Assist.) (See para T8.119 and T8.120 of explanatory notes to this Category) Fee: \$698.75 Benefit: 75% = \$524.10
	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
† 50600	SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital or approved day-hospital facility (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$384.10 Benefit: 75% = \$288.10 85% = \$326.50
† 50604	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$1,630.40 Benefit: 75% = \$1,222.80
† 50608	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$3,028.20 Benefit: 75% = \$2,271.15
† 50612	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$4,307.30 Benefit: 75% = \$3,230.50
† 50616	SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$547.30 Benefit: 75% = \$410.50

OPERATIONS	RADIOFREQUENCY ABLATION
† 50620	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$3,028.20 Benefit: 75% = \$2,271.15
† 50624	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$3,028.20 Benefit: 75% = \$2,271.15
† 50628	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$3,740.60 Benefit: 75% = \$2,805.45
† 50632	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$3,144.55 Benefit: 75% = \$2,358.45
† 50636	SCOLIOSIS, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$3,494.00 Benefit: 75% = \$2,620.50
† 50640	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$1,931.45 Benefit: 75% = \$1,448.60
† 50644	SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$1,863.55 Benefit: 75% = \$1,397.70
TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS	
† 50650	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.) (See para T8.119 of explanatory notes to this Category) Fee: \$366.50 Benefit: 75% = \$274.90 85% = \$311.55
† 50654	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.) (See para T8.119 of explanatory notes to this Category) Fee: \$438.90 Benefit: 75% = \$329.20
† 50658	HIP DYSPLASIA or DISLOCATION, in a child, examination and manipulation of the hip under anaesthesia (Anaes.) (See para T8.119 of explanatory notes to this Category) Fee: \$174.75 Benefit: 75% = \$131.10 85% = \$148.55
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: \$722.05 Benefit: 75% = \$541.55 85% = \$658.15
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 T8.121 of explanatory notes to this Category) Fee: \$722.05 Benefit: 75% = \$541.55 85% = \$658.15

ASSISTANCE AT OPERATIONS	ASSISTANCE AT OPERATIONS
GROUP T9 - ASSISTANCE AT OPERATIONS	
	<p>NOTE: Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more than one medical practitioner.</p> <p>Assistance at any operation identified by the word "Assist." for which the fee does not exceed \$493.35 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 \$493.35 (See para T9.2 of explanatory notes to this Category)</p>
‡ 51300	<p>Fee: \$76.25 Benefit: 75% = \$57.20 85% = \$64.85</p>
‡ 51303	<p>Assistance at any operation identified by the word "Assist." for which the fee exceeds \$493.35 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds \$493.35 (See para T9.3 of explanatory notes to this Category)</p> <p>Derived Fee: one fifth of the established fee for the operation or combination of operations</p>
51306	<p>Assistance at a delivery involving Caesarean section Fee: \$110.20 Benefit: 75% = \$82.65 85% = \$93.70</p>
51309	<p>Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section (See para T9.4 of explanatory notes to this Category)</p> <p>Derived Fee: one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)</p>
51312	<p>Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 Derived Fee: one fifth of the established fee for the procedure or combination of procedures</p>
51315	<p>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: \$240.65 Benefit: 75% = \$180.50 85% = \$204.60</p>
51318	<p>Assistance at cataract and intraocular lens surgery where patient has:</p> <ul style="list-style-type: none"> - total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or - pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage <p>Fee: \$158.85 Benefit: 75% = \$119.15 85% = \$135.05</p>

CATEGORY 4 - ORAL AND MAXILLOFACIAL SERVICES
(by Approved Dental Practitioners)

OUTLINE OF ARRANGEMENTS

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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 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 -

- the sole purpose of granting approval to dental practitioners is to enable payment of Medicare benefits;
- 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.

ORAL & MAXILLOFACIAL	ORAL & MAXILLOFACIAL
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)	
<i>(The referral must be from a registered dental practitioner or a medical practitioner)</i>	
- INITIAL attendance in a single course of treatment <i>(See para OC.5 of explanatory notes to this Category)</i>	
51700	Fee: \$75.60 Benefit: 75% = \$56.70 85% = \$64.30
- Each attendance SUBSEQUENT to the first in a single course of treatment <i>(See para OC.5 of explanatory notes to this Category)</i>	
51703	Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30
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 \$493.35 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 \$493.35 <i>(See para OC.6 of explanatory notes to this Category)</i>	
‡ 51800	Fee: \$76.25 Benefit: 75% = \$57.20 85% = \$64.85
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 \$493.35 or at a series or combination of operations identified by the word "Assist." where the aggregate fee exceeds \$493.35 <i>(See para OC.6 of explanatory notes to this Category)</i>	
‡ 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.) <i>(See para OC.7 of explanatory notes to this Category)</i>	
51900	Fee: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90
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: \$65.30 Benefit: 75% = \$49.00 85% = \$55.55
LIPECTOMY - in the oral and maxillofacial region - wedge excision of skin or fat - 1 EXCISION (Anaes.) (Assist.)	
51904	Fee: \$401.90 Benefit: 75% = \$301.45 85% = \$341.65
LIPECTOMY - in the oral and maxillofacial region - wedge excision of skin or fat - 2 OR MORE EXCISIONS (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i>	
51906	Fee: \$611.30 Benefit: 75% = \$458.50 85% = \$547.40
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: \$72.90 Benefit: 75% = \$54.70 85% = \$62.00
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: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30
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: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30

ORAL & MAXILLOFACIAL	ORAL & MAXILLOFACIAL
52009	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) Fee: \$164.05 Benefit: 75% = \$123.05 85% = \$139.45
52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) Fee: \$224.40 Benefit: 75% = \$168.30 85% = \$190.75
52012	SUPERFICIAL FOREIGN BODY, in the oral and maxillofacial region, removal of, as an independent procedure (Anaes.) Fee: \$20.75 Benefit: 75% = \$15.60 85% = \$17.65
52015	SUBCUTANEOUS FOREIGN BODY, in the oral and maxillofacial region, removal of, requiring incision and suture, as an independent procedure (Anaes.) Fee: \$97.10 Benefit: 75% = \$72.85 85% = \$82.55
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: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90
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: \$26.05 Benefit: 75% = \$19.55 85% = \$22.15
52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, in the oral and maxillofacial region, as an independent procedure (Anaes.) Fee: \$46.15 Benefit: 75% = \$34.65 85% = \$39.25
52025	LYMPH NODE OF NECK, biopsy of (Anaes.) Fee: \$162.50 Benefit: 75% = \$121.90 85% = \$138.15
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: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50
52030	SINUS, in the oral and maxillofacial region, excision of, involving superficial tissue only (Anaes.) Fee: \$79.50 Benefit: 75% = \$59.65 85% = \$67.60
52033	SINUS, in the oral and maxillofacial region, excision of, involving muscle and deep tissue (Anaes.) Fee: \$162.50 Benefit: 75% = \$121.90 85% = \$138.15
52034	PREMALIGNANT LESIONS of the oral mucous, treatment by <u>cryotherapy, diathermy or carbon dioxide laser</u> Fee: \$37.95 Benefit: 75% = \$28.50 85% = \$32.30
52035	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions of the oral cavity (Anaes.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$420.70 Benefit: 75% = \$315.55 85% = \$357.60
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90
52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$152.45 Benefit: 75% = \$114.35 85% = \$129.60

ORAL & MAXILLOFACIAL	ORAL & MAXILLOFACIAL
52045	<p>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)</p> <p>Fee: \$217.80 Benefit: 75% = \$163.35 85% = \$185.15</p>
52048	<p>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)</p> <p>Fee: \$328.30 Benefit: 75% = \$246.25 85% = \$279.10</p>
52051	<p>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)</p> <p>Fee: \$443.85 Benefit: 75% = \$332.90 85% = \$379.95</p>
52054	<p>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)</p> <p>Fee: \$519.25 Benefit: 75% = \$389.45 85% = \$455.35</p>
52055	<p>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)</p> <p>Fee: \$24.15 Benefit: 75% = \$18.15 85% = \$20.55</p>
52056	<p>HAEMATOMA IN THE ORAL AND MAXILLOFACIAL REGION, aspiration of (Anaes.) (See para OC.7 of explanatory notes to this Category)</p> <p>Fee: \$24.15 Benefit: 75% = \$18.15 85% = \$20.55</p>
52057	<p>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.)</p> <p>Fee: \$144.00 Benefit: 75% = \$108.00 85% = \$122.40</p>
52058	<p>PERCUTANEOUS DRAINAGE OF DEEP ABSCESS IN THE ORAL AND MAXILLOFACIAL REGION, using interventional imaging techniques - but not including imaging (Anaes.)</p> <p>Fee: \$209.95 Benefit: 75% = \$157.50 85% = \$178.50</p>
52059	<p>ABSCESS IN THE ORAL AND MAXILLOFACIAL REGION DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.)</p> <p>Fee: \$236.50 Benefit: 75% = \$177.40 85% = \$201.05</p>
52060	<p>MUSCLE IN THE ORAL AND MAXILLOFACIAL REGION, excision of (Anaes.)</p> <p>Fee: \$167.35 Benefit: 75% = \$125.55 85% = \$142.25</p>
52061	<p>MUSCLE, IN THE ORAL AND MAXILLOFACIAL REGION, RUPTURED, repair of (limited), not associated with external wound (Anaes.)</p> <p>Fee: \$197.60 Benefit: 75% = \$148.20 85% = \$168.00</p>
52062	<p>MUSCLE, IN THE ORAL AND MAXILLOFACIAL REGION, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.)</p> <p>Fee: \$261.25 Benefit: 75% = \$195.95 85% = \$222.10</p>
52063	<p>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.)</p> <p>Fee: \$314.90 Benefit: 75% = \$236.20 85% = \$267.70</p>
52064	<p>BONE CYST IN THE ORAL AND MAXILLOFACIAL REGION, injection into or aspiration of (Anaes.)</p> <p>Fee: \$149.80 Benefit: 75% = \$112.35 85% = \$127.35</p>
52066	<p>SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.)</p> <p>Fee: \$393.60 Benefit: 75% = \$295.20 85% = \$334.60</p>

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
52069	SUBLINGUAL GLAND, extirpation of (Anaes.) Fee: \$175.45 Benefit: 75% = \$131.60 85% = \$149.15		
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) Fee: \$51.95 Benefit: 75% = \$39.00 85% = \$44.20		
52073	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50		
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.) Fee: \$132.30 Benefit: 75% = \$99.25 85% = \$112.50		
52078	TONGUE, partial excision of (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95 85% = \$222.10		
52081	TONGUE TIE, division or excision of frenulum (Anaes.) Fee: \$41.10 Benefit: 75% = \$30.85 85% = \$34.95		
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a person aged not less than 2 years (Anaes.) Fee: \$105.55 Benefit: 75% = \$79.20 85% = \$89.75		
52087	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) Fee: \$180.85 Benefit: 75% = \$135.65 85% = \$153.75		
52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) Fee: \$314.90 Benefit: 75% = \$236.20 85% = \$267.70		
52092	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) Fee: \$410.45 Benefit: 75% = \$307.85 85% = \$348.90		
52094	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 52092 (Anaes.) (Assist.) Fee: \$519.20 Benefit: 75% = \$389.40 85% = \$455.30		
52095	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.) Fee: \$336.45 Benefit: 75% = \$252.35 85% = \$286.00		
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.) Fee: \$99.75 Benefit: 75% = \$74.85 85% = \$84.80		
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: \$141.45 Benefit: 75% = \$106.10 85% = \$120.25		
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: \$166.35 Benefit: 75% = \$124.80 85% = \$141.40		
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: \$124.80 Benefit: 75% = \$93.60 85% = \$106.10		
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: \$124.80 Benefit: 75% = \$93.60 85% = \$106.10		
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: \$232.95 Benefit: 75% = \$174.75 85% = \$198.05		

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
52106	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, <u>removal of</u> , requiring general anaesthesia where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$96.25 Benefit: 75% = \$72.20 85% = \$81.85		
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.) Fee: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90		
52111	VERMILIONECTOMY (Anaes.) (Assist.) Fee: \$288.10 Benefit: 75% = \$216.10 85% = \$244.90		
52114	MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45 85% = \$455.35		
52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes.) (Assist.) Fee: \$618.05 Benefit: 75% = \$463.55 85% = \$554.15		
52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes.) (Assist.) Fee: \$728.60 Benefit: 75% = \$546.45 85% = \$664.70		
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: \$731.00 Benefit: 75% = \$548.25 85% = \$667.10		
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) Fee: \$827.60 Benefit: 75% = \$620.70 85% = \$763.70		
52126	MAXILLA, total resection of (Anaes.) (Assist.) Fee: \$795.65 Benefit: 75% = \$596.75 85% = \$731.75		
52129	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) Fee: \$1,065.10 Benefit: 75% = \$798.85 85% = \$1,001.20		
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: \$390.95 Benefit: 75% = \$293.25 85% = \$332.35		
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: \$540.75 Benefit: 75% = \$405.60 85% = \$476.85		
52132	TRACHEOSTOMY (Anaes.) Fee: \$211.05 Benefit: 75% = \$158.30 85% = \$179.40		
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) Fee: \$80.45 Benefit: 75% = \$60.35 85% = \$68.40		
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: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45		
52138	MAXILLARY ARTERY, ligation of (Anaes.) (Assist.) Fee: \$393.60 Benefit: 75% = \$295.20 85% = \$334.60		
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: \$392.05 Benefit: 75% = \$294.05 85% = \$333.25		
52144	FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) Fee: \$365.40 Benefit: 75% = \$274.05 85% = \$310.60		
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) Fee: \$344.80 Benefit: 75% = \$258.60 85% = \$293.10		
52148	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) Fee: \$609.55 Benefit: 75% = \$457.20 85% = \$545.65		

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
52158	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) Fee: \$981.45 Benefit: 75% = \$736.10 85% = \$917.55		
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: \$166.35 Benefit: 75% = \$124.80 85% = \$141.40		
52182	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of (Anaes.) (Assist.) Fee: \$366.10 Benefit: 75% = \$274.60 85% = \$311.20		
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: \$540.75 Benefit: 75% = \$405.60 85% = \$476.85		
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: \$665.60 Benefit: 75% = \$499.20 85% = \$601.70		
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: \$251.25 Benefit: 75% = \$188.45 85% = \$213.60		
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: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00		
52306	SINGLE-STAGE LOCAL FLAP, in the oral and maxillofacial region, where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) Fee: \$532.35 Benefit: 75% = \$399.30 85% = \$468.45		
52309	FREE GRAFTING (mucosa or split skin) of a granulating area in the oral and maxillofacial region, (Anaes.) Fee: \$180.85 Benefit: 75% = \$135.65 85% = \$153.75		
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect in the oral and maxillofacial region, including elective dissection (Anaes.) (Assist.) Fee: \$251.25 Benefit: 75% = \$188.45 85% = \$213.60		
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) in the oral and maxillofacial region (Anaes.) (Assist.) Fee: \$418.65 Benefit: 75% = \$314.00 85% = \$355.90		
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: \$124.80 Benefit: 75% = \$93.60 85% = \$106.10		
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: \$207.70 Benefit: 75% = \$155.80 85% = \$176.55		
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: \$418.65 Benefit: 75% = \$314.00 85% = \$355.90		
52324	DIRECT FLAP REPAIR, using tongue, first stage (Anaes.) (Assist.) Fee: \$418.65 Benefit: 75% = \$314.00 85% = \$355.90		
52327	DIRECT FLAP REPAIR, using tongue, second stage (Anaes.) Fee: \$207.70 Benefit: 75% = \$155.80 85% = \$176.55		

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.) Fee: \$690.95	Benefit: 75% = \$518.25	85% = \$627.05
52333	CLEFT PALATE, primary repair (Anaes.) (Assist.) Fee: \$690.95	Benefit: 75% = \$518.25	85% = \$627.05
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.) Fee: \$431.90	Benefit: 75% = \$323.95	85% = \$368.00
52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) Fee: \$944.70	Benefit: 75% = \$708.55	85% = \$880.80
52339	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) Fee: \$491.85	Benefit: 75% = \$368.90	85% = \$427.95
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.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$854.25	Benefit: 75% = \$640.70	85% = \$790.35
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.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$963.45	Benefit: 75% = \$722.60	85% = \$899.55
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.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$1,088.70	Benefit: 75% = \$816.55	85% = \$1,024.80
52351	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$1,222.65	Benefit: 75% = \$917.00	85% = \$1,158.75
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.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$1,239.50	Benefit: 75% = \$929.65	85% = \$1,175.60
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.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$1,395.45	Benefit: 75% = \$1,046.60	85% = \$1,331.55
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.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$1,423.60	Benefit: 75% = \$1,067.70	85% = \$1,359.70
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.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$1,601.50	Benefit: 75% = \$1,201.15	85% = \$1,537.60
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.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$1,566.10	Benefit: 75% = \$1,174.60	85% = \$1,502.20

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
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: \$1,760.80	Benefit: 75% = \$1,320.60 85% = \$1,696.90
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: \$1,708.55	Benefit: 75% = \$1,281.45 85% = \$1,644.65
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: \$1,913.75	Benefit: 75% = \$1,435.35 85% = \$1,849.85
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: \$661.55	Benefit: 75% = \$496.20 85% = \$597.65
52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.) (Assist.)	Fee: \$1,129.60	Benefit: 75% = \$847.20 85% = \$1,065.70
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: \$1,925.15	Benefit: 75% = \$1,443.90 85% = \$1,861.25
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: \$2,307.70	Benefit: 75% = \$1,730.80 85% = \$2,243.80
52420	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity	Fee: \$213.10	Benefit: 75% = \$159.85 85% = \$181.15
52424	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) IN THE ORAL AND MAXILLOFACIAL REGION (Anaes.) (Assist.)	Fee: \$418.55	Benefit: 75% = \$313.95 85% = \$355.80
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: \$963.45	Benefit: 75% = \$722.60 85% = \$899.55
52440	CLEFT LIP, unilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	Fee: \$478.40	Benefit: 75% = \$358.80 85% = \$414.50
52442	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	Fee: \$598.10	Benefit: 75% = \$448.60 85% = \$534.20
52444	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	Fee: \$664.40	Benefit: 75% = \$498.30 85% = \$600.50
52446	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	Fee: \$784.20	Benefit: 75% = \$588.15 85% = \$720.30
52450	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	Fee: \$265.75	Benefit: 75% = \$199.35 85% = \$225.90
52452	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)	Fee: \$431.90	Benefit: 75% = \$323.95 85% = \$368.00

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
52456	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) Fee: \$731.00 Benefit: 75% = \$548.25 85% = \$667.10		
52458	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) Fee: \$265.75 Benefit: 75% = \$199.35 85% = \$225.90		
52460	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) Fee: \$690.95 Benefit: 75% = \$518.25 85% = \$627.05		
52480	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.) Fee: \$443.85 Benefit: 75% = \$332.90 85% = \$379.95		
52482	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) Fee: \$427.05 Benefit: 75% = \$320.30 85% = \$363.15		
52484	MACROSTOMIA, operation for (Anaes.) (Assist.) Fee: \$508.35 Benefit: 75% = \$381.30 85% = \$444.45		
GROUP O5 - PREPROSTHETIC			
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) Fee: \$298.95 Benefit: 75% = \$224.25 85% = \$254.15		
52603	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) Fee: \$285.80 Benefit: 75% = \$214.35 85% = \$242.95		
52606	MAXILLARY TUBEROSITY, reduction of (Anaes.) Fee: \$218.00 Benefit: 75% = \$163.50 85% = \$185.30		
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) Fee: \$285.80 Benefit: 75% = \$214.35 85% = \$242.95		
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) Fee: \$358.80 Benefit: 75% = \$269.10 85% = \$305.00		
52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) Fee: \$445.25 Benefit: 75% = \$333.95 85% = \$381.35		
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) Fee: \$518.20 Benefit: 75% = \$388.65 85% = \$454.30		
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) Fee: \$518.20 Benefit: 75% = \$388.65 85% = \$454.30		
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) Fee: \$418.55 Benefit: 75% = \$313.95 85% = \$355.80		
52626	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) Fee: \$256.70 Benefit: 75% = \$192.55 85% = \$218.20		
52627	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.) Fee: \$445.25 Benefit: 75% = \$333.95 85% = \$381.35		
52630	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.) Fee: \$164.80 Benefit: 75% = \$123.60 85% = \$140.10		
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: \$445.25 Benefit: 75% = \$333.95 85% = \$381.35		

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
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: \$164.80 Benefit: 75% = \$123.60 85% = \$140.10		
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: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90		
52803	NERVE TRUNK, internal (interfascicular), in the oral and maxillofacial region, NEUROLYSIS of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$352.15 Benefit: 75% = \$264.15 85% = \$299.35		
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve in the oral and maxillofacial region (Anaes.) (Assist.) Fee: \$244.55 Benefit: 75% = \$183.45 85% = \$207.90		
52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve in the oral and maxillofacial region (Anaes.) (Assist.) Fee: \$418.65 Benefit: 75% = \$314.00 85% = \$355.90		
52812	NERVE TRUNK, in the oral and maxillofacial region, PRIMARY repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$598.10 Benefit: 75% = \$448.60 85% = \$534.20		
52815	NERVE TRUNK, in the oral and maxillofacial region, SECONDARY repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$631.20 Benefit: 75% = \$473.40 85% = \$567.30		
52818	NERVE, in the oral and maxillofacial region, TRANSPOSITION OF (Anaes.) (Assist.) Fee: \$418.65 Benefit: 75% = \$314.00 85% = \$355.90		
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: \$910.30 Benefit: 75% = \$682.75 85% = \$846.40		
52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) Fee: \$392.05 Benefit: 75% = \$294.05 85% = \$333.25		
52826	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) Fee: \$209.95 Benefit: 75% = \$157.50 85% = \$178.50		
52828	CUTANEOUS NERVE, in the oral and maxillofacial region, primary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$312.25 Benefit: 75% = \$234.20 85% = \$265.45		
52830	CUTANEOUS NERVE, in the oral and maxillofacial region, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$411.85 Benefit: 75% = \$308.90 85% = \$350.10		
52832	CUTANEOUS NERVE, in the oral and maxillofacial region, nerve graft to, using microsurgical techniques (Anaes.) (Assist.) Fee: \$564.80 Benefit: 75% = \$423.60 85% = \$500.90		
GROUP O7 - EAR, NOSE & THROAT			
53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) Fee: \$28.70 Benefit: 75% = \$21.55 85% = \$24.40		
53003	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) Fee: \$81.25 Benefit: 75% = \$60.95 85% = \$69.10		
53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes.) Fee: \$29.65 Benefit: 75% = \$22.25 85% = \$25.25		

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
53006	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) Fee: \$460.55 Benefit: 75% = \$345.45 85% = \$396.65		
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) Fee: \$261.25 Benefit: 75% = \$195.95 85% = \$222.10		
53012	ANTRUM, drainage of, through tooth socket (Anaes.) Fee: \$103.85 Benefit: 75% = \$77.90 85% = \$88.30		
53015	ORO-ANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) Fee: \$519.25 Benefit: 75% = \$389.45 85% = \$455.35		
53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.) Fee: \$427.05 Benefit: 75% = \$320.30 85% = \$363.15		
53017	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) Fee: \$532.75 Benefit: 75% = \$399.60 85% = \$468.85		
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) Fee: \$513.25 Benefit: 75% = \$384.95 85% = \$449.35		
53052	POST-NASAL SPACE, direct examination of, with or without biopsy (Anaes.) Fee: \$108.55 Benefit: 75% = \$81.45 85% = \$92.30		
53054	NASENOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.) Fee: \$108.50 Benefit: 75% = \$81.40 85% = \$92.25		
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: \$63.55 Benefit: 75% = \$47.70 85% = \$54.05		
53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) Fee: \$108.50 Benefit: 75% = \$81.40 85% = \$92.25		
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: \$88.80 Benefit: 75% = \$66.60 85% = \$75.50		
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) Fee: \$79.50 Benefit: 75% = \$59.65 85% = \$67.60		
53064	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) Fee: \$144.00 Benefit: 75% = \$108.00 85% = \$122.40		
53068	TURBINECTOMY or TURBINECTOMIES, partial or total, unilateral (Anaes.) Fee: \$119.20 Benefit: 75% = \$89.40 85% = \$101.35		
53070	TURBINATES, submucous resection of, unilateral (Anaes.) Fee: \$157.30 Benefit: 75% = \$118.00 85% = \$133.75		
GROUP O8 - TEMPOROMANDIBULAR JOINT			
53200	MANDIBLE, treatment of a dislocation of, not requiring open reduction (Anaes.) Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15		
53203	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) Fee: \$104.95 Benefit: 75% = \$78.75 85% = \$89.25		

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
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: \$126.30 Benefit: 75% = \$94.75 85% = \$107.40		
53209	GLENOID FOSSA, ZYGOMATIC ARCH and TEMPORAL BONE, reconstruction of (Obwegeser technique) (Anaes.) (Assist.) Fee: \$1,457.20 Benefit: 75% = \$1,092.90 85% = \$1,393.30		
53212	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) Fee: \$787.20 Benefit: 75% = \$590.40 85% = \$723.30		
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: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00		
53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes.) (Assist.) Fee: \$577.70 Benefit: 75% = \$433.30 85% = \$513.80		
53220	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$291.25 Benefit: 75% = \$218.45 85% = \$247.60		
53221	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$770.80 Benefit: 75% = \$578.10 85% = \$706.90		
53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$854.45 Benefit: 75% = \$640.85 85% = \$790.55		
53225	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) Fee: \$256.70 Benefit: 75% = \$192.55 85% = \$218.20		
53226	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$276.00 Benefit: 75% = \$207.00 85% = \$234.60		
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: \$1,049.95 Benefit: 75% = \$787.50 85% = \$986.05		
53230	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$1,182.75 Benefit: 75% = \$887.10 85% = \$1,118.85		
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: \$1,329.00 Benefit: 75% = \$996.75 85% = \$1,265.10		
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: \$415.90 Benefit: 75% = \$311.95 85% = \$353.55		
53239	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$415.90 Benefit: 75% = \$311.95 85% = \$353.55		
53242	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) Fee: \$276.00 Benefit: 75% = \$207.00 85% = \$234.60		

ORAL & MAXILLOFACIAL	ORAL & MAXILLOFACIAL
GROUP O9 - TREATMENT OF FRACTURES	
53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$114.15 Benefit: 75% = \$85.65 85% = \$97.05
53403	MANDIBLE, treatment of fracture of, not requiring splinting <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$139.45 Benefit: 75% = \$104.60 85% = \$118.55
53406	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$359.35 Benefit: 75% = \$269.55 85% = \$305.45
53409	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$359.35 Benefit: 75% = \$269.55 85% = \$305.45
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$75.70 Benefit: 75% = \$56.80 85% = \$64.35
53411	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$211.05 Benefit: 75% = \$158.30 85% = \$179.40
53412	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$346.50 Benefit: 75% = \$259.90 85% = \$294.55
53413	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$423.40 Benefit: 75% = \$317.55 85% = \$359.90
53414	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$487.60 Benefit: 75% = \$365.70 85% = \$423.70
53415	MAXILLA, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$385.00 Benefit: 75% = \$288.75 85% = \$327.25
53416	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$385.00 Benefit: 75% = \$288.75 85% = \$327.25
53418	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$500.45 Benefit: 75% = \$375.35 85% = \$436.55
53419	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$500.45 Benefit: 75% = \$375.35 85% = \$436.55
53422	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$635.10 Benefit: 75% = \$476.35 85% = \$571.20
53423	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$635.10 Benefit: 75% = \$476.35 85% = \$571.20

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
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: \$544.90 Benefit: 75% = \$408.70 85% = \$481.00		
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: \$544.90 Benefit: 75% = \$408.70 85% = \$481.00		
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: \$744.25 Benefit: 75% = \$558.20 85% = \$680.35		
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: \$744.25 Benefit: 75% = \$558.20 85% = \$680.35		
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) (See para OC.7 of explanatory notes to this Category) Fee: \$211.05 Benefit: 75% = \$158.30 85% = \$179.40		
53453	ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.) Fee: \$427.05 Benefit: 75% = \$320.30 85% = \$363.15		
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) Fee: \$501.60 Benefit: 75% = \$376.20 85% = \$437.70		
53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies Fee: \$38.00 Benefit: 75% = \$28.50 85% = \$32.30		
53459	NASAL BONES, treatment of fracture of, by reduction (Anaes.) Fee: \$208.05 Benefit: 75% = \$156.05 85% = \$176.85		
53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.) Fee: \$424.45 Benefit: 75% = \$318.35 85% = \$360.80		
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: \$34.40 Benefit: 75% = \$25.80 85% = \$29.25		
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: \$110.30 Benefit: 75% = \$82.75 85% = \$93.80		
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent Fee: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00		
53704	FACIAL NERVE, injection of an anaesthetic agent Fee: \$33.25 Benefit: 75% = \$24.95 85% = \$28.30		
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: \$110.30 Benefit: 75% = \$82.75 85% = \$93.80		

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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, 55135, 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 – ‘Exemptions from the written request requirements for R-type diagnostic imaging services’), 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.

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

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 DID - 'Exemptions from the written request requirements for R-type diagnostic imaging services'

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.
- A medical practitioner, on behalf of the treating practitioner, for example, by a resident medical officer at a hospital on behalf of the patient's treating 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.

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.

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.

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.

Contravention of request requirements

A practitioner who, without reasonable excuse makes a request for a diagnostic imaging service that does not include the required information in his or her request or in a request made on his or her behalf is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of \$1000.

A 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.

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 and these are outlined as follows:

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 “*Additional services*”.

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 (practitioners should claim the NR item in these circumstances);
- MRI services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see DIF.

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.

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.

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.

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.

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.

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 <http://www.medicareaustralia.gov.au/providers/forms/medicare/lspn.htm> A list of LSPN registrations is available on Medicare Australia's website at www.medicareaustralia.gov.au/yourhealth/our_services/lspn_search.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* 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 MULTIPLE DIAGNOSTIC IMAGING SERVICES

Background

There are several rules that may apply when calculating Medicare benefits payable when multiple diagnostic imaging services are provided to a patient at the same attendance (same day). These rules were developed in association with the diagnostic imaging profession representative organisations and reflect that there are efficiencies to the provider when these services are performed on the same occasion. Unless there are clinical reasons for doing so, they should be provided to the patient at the one attendance and the efficiencies from doing this reflected in the overall fee charged.

General diagnostic imaging - multiples services

The diagnostic imaging 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.

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.

Ultrasound - Vascular

This rule applies 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.

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

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 55238 and 55280, item 55238 would be considered the highest.

When calculating the benefit, it should be noted that despite the reduction, the collective items are treated as one service for the application of Rule A of the General Diagnostic Imaging Multiple Services rules and the patient gap. Examples can be found at: www.medicareaustralia.gov.au/providers/publications_guidelines/medical_practitioners.htm

Ultrasound - Musculoskeletal

Items 55800 to 55854 apply only once a day for each patient for which a service described in any of those items is provided, regardless of the number of regions scanned in performing the service.

Magnetic Resonance Imaging (MRI) - Musculoskeletal

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%.

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 63322 and 63331, item 63322 would be considered the highest.

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.

If a medical practitioner provides:

- (a) 2 or more MRI services from subgroups 12 and 13 for the same patient on the same day; and
(b) 1 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 in applying Rule A of the General Diagnostic Imaging Multiple Services rules.

DIK GROUP II - ULTRASOUND

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.

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>

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).

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.

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".

Subgroup 1 – General Ultrasound

Post-void residual items 55084 and 55085

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

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

Subgroup 2 – Cardiac ultrasound

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.

Subgroup 3 - Vascular ultrasound

Benefits payable

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.
- 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.

Multiple Vascular Ultrasound Services – refer to DIJ

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.

Examination of peripheral vessels

Vascular ultrasound services can be claimed in conjunction with item 11612.

Subgroup 4: Urological ultrasound

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.

Subgroup 5: Obstetric and Gynaecological ultrasound

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.

Clinical indications

For items where clinical indications are listed (items 55700, 55704, 55707, 55718, 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, 55708, 55715, 55723, 55725, 55762, 55766, 55770 and 55774), the clinical condition or indication must be recorded in the medical practitioner's clinical notes.

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 Obstetricians 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.

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.

Obstetric ultrasound and non-metropolitan providers (Items 55712, 55721, 55764 and 55772)

Where a practitioner has obstetric privileges at a non-metropolitan hospital and refers for items 55712, 55721 and 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, 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).

Subgroup 6: Musculoskeletal (MSK) ultrasound

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 for definition of remote area. Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

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.

Single rebate

Items 55800 to 55854 apply once a day for each patient regardless of the number of regions scanned in performing the service/s – refer DIJ Multiple Services – Ultrasound -Musculoskeletal.

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 ultrasound examination and reporting of one limb only. Comparison views are considered to be part of the examination requested.

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 not payable when referred for non-specific shoulder pain alone.

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

- meniscal and cruciate ligament tears; and
- assessment of chondral surfaces.

DIL GROUP I2: COMPUTED TOMOGRAPHY (CT)

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.

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.

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.

Use of a hybrid PET/CT or SPECT/CT machine

CT scans rendered on hybrid Positron Emission Tomography (PET)/CT or hybrid Single Photon Emission Computed Tomography (SPECT)/CT units are eligible for a Medicare benefit provided:

- the CT scan is not solely used for the purposes of attenuation correction and anatomical correlation of any associated PET or SPECT scan; and
- the CT scan is rendered under the same conditions as those applying to services rendered on stand-alone CT equipment. For example, the service would need to be properly requested and performed under the professional supervision of a specialist radiologist, including specialist radiologists with dual nuclear medicine qualifications.

Scan of more than one area

Items have been provided to cover the common combinations of regions – see Multiple Regions below. 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.

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.

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.

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.

Head

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.

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.

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.

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).

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.

Spiral angiography

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.

Spiral angiography/chest items not to be used to image the coronary arteries

CT coronary angiography is a technology that has not yet been assessed by the Medical Services Advisory Committee. The descriptors for CT spiral angiography items 57350, 57351, 57355 and 57356 and CT chest items 56301, 56307, 56341, 56347, 56801, 56807, 56841, 56847, 57001, 57007, 57041 and 57047 clarify that they are not to be used to image the coronary arteries.

DIM GROUP I3: DIAGNOSTIC RADIOLOGY

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.

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.

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.

Subgroup 4: Radiographic examination of the spine

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.

Subgroup 8: Radiographic examination of alimentary tract and biliary system

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.

Subgroup 10: Radiographic examination of the breasts

Request requirements (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.

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.

Subgroup 12: Radiographic examination with opaque or contrast media

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.

Subgroup 13: Angiography

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.

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.

Subgroup 16: Preparation for radiological procedure

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

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.

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.

Radiopharmaceuticals

The Schedule fees for nuclear medicine imaging services incorporate the costs of radiopharmaceuticals.

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.

Single myocardial perfusion studies (Items 61302 and 61303)

Items 61302 and 61303 apply to single myocardial perfusion studies which can only be used once and cannot be used in conjunction with any other myocardial perfusion study for an individual patient referral.

Myocardial perfusion (Items 61306 and 61307)

Items 61306 and 61307 refer to all myocardial perfusion studies involving two or more sets of imaging times related to an individual patient referral. This includes stress/rest, stress/re-injection, stress/rest and re-injection thallium studies, one or two-day technetium-based perfusion agent protocols, mixed technetium-based perfusion agent/thallium protocols and the use of gated SPECT when undertaken.

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.

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.

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.

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.

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)

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.

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.

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.

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).

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

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.

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.

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.

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.

MRI Musculoskeletal (MSK) Multiple Services – refer to DIJ

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.

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.

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).

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

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.

ULTRASOUND		GENERAL
GROUP II - ULTRASOUND		
SUBGROUP 1 - GENERAL		
55028	<p>HEAD, ultrasound scan of, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>	
55029	<p>HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>	
55030	<p>ORBITAL CONTENTS, ultrasound scan of, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>	
55031	<p>ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>	
55032	<p>NECK, 1 or more structures of, ultrasound scan of, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>	
55033	<p>NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>	
55036	<p>ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies;</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(c) the service is not performed with item 55038, 55044 or 55731 on the same patient within 24 hours (R)</p> <p>Fee: \$111.30 Benefit: 75% = \$83.50 85% = \$94.65</p>	
55037	<p>ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>	
55038	<p>URINARY TRACT, ultrasound scan of but not being a service associated with the service described in item 55600 or item 55603, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(c) the service is not performed with item 55036, 55044 or 55731 on the same patient within 24 hours (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>	
55039	<p>URINARY TRACT, ultrasound scan of, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>	

ULTRASOUND	CARDIAC
55044	<p>PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies;</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(c) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R)</p> <p>Fee: \$111.30 Benefit: 75% = \$83.50 85% = \$94.65</p>
55045	<p>PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55048	<p>SCROTUM, ultrasound scan of, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.50 Benefit: 75% = \$82.15 85% = \$93.10</p>
55049	<p>SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55054	<p>ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55070	<p>BREAST, one, ultrasound scan of, where:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$98.25 Benefit: 75% = \$73.70 85% = \$83.55</p>
55073	<p>BREAST, one, ultrasound scan of, where:</p> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR)</p> <p>Fee: \$34.05 Benefit: 75% = \$25.55 85% = \$28.95</p>
55076	<p>BREASTS, both, ultrasound scan of, where:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55079	<p>BREASTS, both, ultrasound scan of, where:</p> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55084	<p>URINARY BLADDER, ultrasound scan of, by any or all approaches, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of the Group applies; and</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(c) the service is not performed with item 55600, 55603, 55036, 55038, 55044, 55731 or 11917 on the same date of service (R)</p> <p>Fee: \$98.25 Benefit: 75% = \$73.70 85% = \$83.55</p>
55085	<p>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)</p> <p>Fee: \$34.05 Benefit: 75% = \$25.55 85% = \$28.95</p>

ULTRASOUND	VASCULAR
SUBGROUP 2 - CARDIAC	
55113	<p>M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (R)</p> <p>Fee: \$226.05 Benefit: 75% = \$169.55 85% = \$192.15</p>
55114	<p>M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (R)</p> <p>Fee: \$226.05 Benefit: 75% = \$169.55 85% = \$192.15</p>
55115	<p>M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of congenital heart disease (R)</p> <p>Fee: \$226.05 Benefit: 75% = \$169.55 85% = \$192.15</p>
55116	<p>EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R)</p> <p>Fee: \$256.50 Benefit: 75% = \$192.40 85% = \$218.05</p>
55117	<p>PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R)</p> <p>Fee: \$256.50 Benefit: 75% = \$192.40 85% = \$218.05</p>
55118	<p>HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level:</p> <p>(a) with:</p> <p style="padding-left: 20px;">(i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and</p> <p style="padding-left: 20px;">(ii) recordings on video tape or digital medium; and</p> <p>(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.)</p> <p>Fee: \$275.50 Benefit: 75% = \$206.65 85% = \$234.20</p>
55130	<p>INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with item 55135 (R) (Anaes.)</p> <p>Fee: \$170.00 Benefit: 75% = \$127.50 85% = \$144.50</p>
55135	<p>INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac 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.)</p> <p>Fee: \$353.60 Benefit: 75% = \$265.20 85% = \$300.60</p>

ULTRASOUND	VASCULAR
SUBGROUP 3 - VASCULAR	
55238	<p>DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55244	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55246	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55248	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55252	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55274	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55276	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55278	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55280	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55282	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>

ULTRASOUND	UROLOGICAL
55284	<p>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:</p> <ul style="list-style-type: none"> (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; <p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55292	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55294	<p>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)</p> <p>Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10</p>
55296	<p>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)</p> <p>Fee: \$111.05 Benefit: 75% = \$83.30 85% = \$94.40</p>
SUBGROUP 4 - UROLOGICAL	
55600	<p>PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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) <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55603	<p>PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed:</p> <ul style="list-style-type: none"> (a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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) <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>

SUBGROUP 5 - OBSTETRIC AND GYNAECOLOGICAL

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:

- (a) the patient is referred by a medical practitioner; and
- (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and
- (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
- (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and
- (e) one or more of the following conditions are present:
 - (i) hyperemesis gravidarum;
 - (ii) diabetes mellitus;
 - (iii) hypertension;
 - (iv) toxemia 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 55700 or item 55707, not both items.

55700

Fee: \$60.00 **Benefit:** 75% = \$45.00 85% = \$51.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:

- (a) the patient is not referred by a medical practitioner; and
- (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and
- (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
- (d) one or more of the following conditions are present:
 - (i) hyperemesis gravidarum;
 - (ii) diabetes mellitus;
 - (iii) hypertension;
 - (iv) toxemia 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.

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) toxemia 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.

55704

Fee: \$70.00 **Benefit:** 75% = \$52.50 85% = \$59.50

<p>55705</p>	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) hyperemesis gravidarum (ii) diabetes mellitus; (iii) hypertension; (iv) toxemia 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) <p>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.</p> <p>Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75</p>
<p>55706</p>	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$100.00 Benefit: 75% = \$75.00 85% = \$85.00</p>
<p>55707</p>	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where;</p> <ul style="list-style-type: none"> (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) <p>Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50</p>

ULTRASOUND

OBSTETRIC AND GYNAECOLOGICAL

55708	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where;</p> <ul style="list-style-type: none"> (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) <p>Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75</p>
55709	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$38.00 Benefit: 75% = \$28.50 85% = \$32.30</p>
55712	<p>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:</p> <ul style="list-style-type: none"> (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 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 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) <p>Fee: \$115.00 Benefit: 75% = \$86.25 85% = \$97.75</p>
55715	<p>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:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$40.00 Benefit: 75% = \$30.00 85% = \$34.00</p>

ULTRASOUND

OBSTETRIC AND GYNAECOLOGICAL

	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and</p> <p>(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(e) the service is not performed in the same pregnancy as item 55723; and</p> <p>(f) one or more of the following conditions are present:</p> <ul style="list-style-type: none"> (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anomaly (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxoemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (R) <p>55718 Fee: \$100.00 Benefit: 75% = \$75.00 85% = \$85.00</p>
55721	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where:</p> <p>(a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has 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</p> <p>(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and</p> <p>(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R)</p> <p>55721 Fee: \$115.00 Benefit: 75% = \$86.25 85% = \$97.75</p>

ULTRASOUND

OBSTETRIC AND GYNAECOLOGICAL

<p>55723</p>	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) 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) <p>Fee: \$38.00 Benefit: 75% = \$28.50 85% = \$32.30</p>
<p>55725</p>	<p>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:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$40.00 Benefit: 75% = \$30.00 85% = \$34.00</p>
<p>55729</p>	<p>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)</p> <p>Fee: \$27.25 Benefit: 75% = \$20.45 85% = \$23.20</p>

ULTRASOUND	OBSTETRIC AND GYNAECOLOGICAL
55731	<p>PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$98.00 Benefit: 75% = \$73.50 85% = \$83.30</p>
55733	<p>PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75</p>
55736	<p>PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$127.00 Benefit: 75% = \$95.25 85% = \$107.95</p>
55739	<p>PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$57.00 Benefit: 75% = \$42.75 85% = \$48.45</p>
55759	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$150.00 Benefit: 75% = \$112.50 85% = \$127.50</p>
55762	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:</p> <ul style="list-style-type: none"> (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 55759 during 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) <p>Fee: \$60.00 Benefit: 75% = \$45.00 85% = \$51.00</p>
55764	<p>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:</p> <ul style="list-style-type: none"> (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 Obstetricians 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) <p>Fee: \$160.00 Benefit: 75% = \$120.00 85% = \$136.00</p>

ULTRASOUND

OBSTETRIC AND GYNAECOLOGICAL

55766	<p>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:</p> <ul style="list-style-type: none"> (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) <p>Fee: \$65.00 Benefit: 75% = \$48.75 85% = \$55.25</p>
‡ 55768	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:</p> <ul style="list-style-type: none"> (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 or 55725 during the same pregnancy (R) <p>Fee: \$150.00 Benefit: 75% = \$112.50 85% = \$127.50</p>
‡ 55770	<p>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:</p> <ul style="list-style-type: none"> (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 or 55725 during the same pregnancy (NR) <p>Fee: \$60.00 Benefit: 75% = \$45.00 85% = \$51.00</p>
‡ 55772	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:</p> <ul style="list-style-type: none"> (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 or 55725 during the same pregnancy (R) <p>Fee: \$160.00 Benefit: 75% = \$120.00 85% = \$136.00</p>
‡ 55774	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, 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:</p> <ul style="list-style-type: none"> (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 or 55725 during the same pregnancy (NR) <p>Fee: \$65.00 Benefit: 75% = \$48.75 85% = \$55.25</p>

ULTRASOUND	MUSCULOSKELETAL
SUBGROUP 6 - MUSCULOSKELETAL	
55800	<p>HAND OR WRIST, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55802	<p>HAND OR WRIST, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55804	<p>FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55806	<p>FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55808	<p>Note: <i>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.</i></p> <p>SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:</p> <ul style="list-style-type: none"> - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(R) <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55810	<p>Note: <i>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.</i></p> <p>SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:</p> <ul style="list-style-type: none"> - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(NR) <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55812	<p>CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55814	<p>CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>

ULTRASOUND	MUSCULOSKELETAL
55816	<p>HIP OR GROIN, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55818	<p>HIP OR GROIN, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55820	<p>PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55822	<p>PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55824	<p>BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55826	<p>BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55828	<p>Note: <i>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:</i></p> <ul style="list-style-type: none"> - meniscal and cruciate ligament tears - assessment of chondral surfaces <p>KNEE, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:</p> <ul style="list-style-type: none"> - 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) <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55830	<p>Note: <i>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:</i></p> <ul style="list-style-type: none"> - meniscal and cruciate ligament tears - assessment of chondral surfaces <p>KNEE, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:</p> <ul style="list-style-type: none"> - 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) <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55832	<p>LOWER LEG, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>

ULTRASOUND	MUSCULOSKELETAL
55834	<p>LOWER LEG, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55836	<p>ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the services is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55838	<p>ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55840	<p>MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55842	<p>MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55844	<p>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:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$87.35 Benefit: 75% = \$65.55 85% = \$74.25</p>
55846	<p>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:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>
55848	<p>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)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55850	<p>MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where:</p> <p>(a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated;</p> <p>(b) the service is not performed in conjunction with items 55054, or 55800 to 55848, and</p> <p>(c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$152.85 Benefit: 75% = \$114.65 85% = \$129.95</p>
55852	<p>PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where:</p> <p>a) the patient is referred by a medical practitioner</p> <p>b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
55854	<p>PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where:</p> <p>a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$37.85 Benefit: 75% = \$28.40 85% = \$32.20</p>

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY	
GROUP I2 - COMPUTED TOMOGRAPHY			
HEAD			
56001	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (K) (Anaes.)	Fee: \$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

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY
56068	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (NK) (Anaes.) Fee: \$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.) 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.) 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.) 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.) 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.) 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.) Fee: \$351.40 Benefit: 75% = \$263.55 85% = \$298.70	

COMPUTED TOMOGRAPHY	COMPUTED TOMOGRAPHY
56226	<p>COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) Fee: \$351.40 Benefit: 75% = \$263.55 85% = \$298.70</p>
56227	<p>COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15</p>
56228	<p>COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15</p>
56229	<p>COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15</p>
56230	<p>COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium, and with any scans to the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$177.45 Benefit: 75% = \$133.10 85% = \$150.85</p>
56231	<p>COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$177.45 Benefit: 75% = \$133.10 85% = \$150.85</p>
56232	<p>COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$177.45 Benefit: 75% = \$133.10 85% = \$150.85</p>
56233	<p><i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i></p> <p>COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56220, 56221 and 56223 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) Fee: \$240.00 Benefit: 75% = \$180.00 85% = \$204.00</p>
56234	<p><i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i></p> <p>COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56224, 56225 and 56226 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) Fee: \$351.40 Benefit: 75% = \$263.55 85% = \$298.70</p>
56235	<p><i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i></p> <p>COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56227, 56228 and 56229 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$122.45 Benefit: 75% = \$91.85 85% = \$104.10</p>
56236	<p><i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i></p> <p>COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56230, 56231 and 56232 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$177.45 Benefit: 75% = \$133.10 85% = \$150.85</p>
56237	<p>COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) Fee: \$240.00 Benefit: 75% = \$180.00 85% = \$204.00</p>

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY
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.) 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.) 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.) 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 or image the coronary arteries (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 or image the coronary arteries (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 or image the coronary arteries (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 or image the coronary arteries (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	

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY
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% = \$416.15	
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.) 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.) Fee: \$334.65 Benefit: 75% = \$251.00 85% = \$284.50	

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY
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.) 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.) 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 or image the coronary arteries (R) (K) (Anaes.) Fee: \$466.55 Benefit: 75% = \$349.95 85% = \$402.65	
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 or image the coronary arteries (R) (K) (Anaes.) Fee: \$560.00 Benefit: 75% = \$420.00 85% = \$496.10	
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 or image the coronary arteries (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 or image the coronary arteries (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 or image the coronary arteries (R) (K) (Anaes.) Fee: \$466.65 Benefit: 75% = \$350.00 85% = \$402.75	
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 or image the coronary arteries (R) (K) (Anaes.) Fee: \$567.75 Benefit: 75% = \$425.85 85% = \$503.85	
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 or image the coronary arteries (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 or image the coronary arteries (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% = \$406.10	

COMPUTED TOMOGRAPHY	COMPUTED TOMOGRAPHY
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57345	<p>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</p>
	SPIRAL ANGIOGRAPHY
57350	<p>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:</p> <p>(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; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.)</p> <p>Fee: \$510.00 Benefit: 75% = \$382.50 85% = \$446.10</p>
57351	<p>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:</p> <p>(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; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.)</p> <p>Fee: \$510.00 Benefit: 75% = \$382.50 85% = \$446.10</p>
57355	<p>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:</p> <p>(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; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.)</p> <p>Fee: \$264.15 Benefit: 75% = \$198.15 85% = \$224.55</p>
57356	<p>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:</p> <p>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; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.)</p> <p>Fee: \$264.15 Benefit: 75% = \$198.15 85% = \$224.55</p>

DIAGNOSTIC RADIOLOGY		EXTREMITIES
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	

DIAGNOSTIC RADIOLOGY		SPINE
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	

DIAGNOSTIC RADIOLOGY		BONE AGE STUDY
	<i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i>	
58112	Spine, two examinations of the kind referred to in items 58100, 58103, 58106 and 58109 (R) Fee: \$97.25 Benefit: 75% = \$72.95 85% = \$82.70	
	<i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i>	
58115	Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) Fee: \$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) Fee: \$35.70 Benefit: 75% = \$26.80 85% = \$30.35	

DIAGNOSTIC RADIOLOGY	LOCALISATION OF FOREIGN BODIES
58903	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (R) 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	DEFAECOGRAPH (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	
<i>(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)</i>	
59300	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) 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) 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

DIAGNOSTIC RADIOLOGY		IN CONNECTION WITH PREGNANCY
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.) 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	

DIAGNOSTIC RADIOLOGY	ANGIOGRAPHY
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.) 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.) 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% = \$500.10
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% = \$763.20
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% = \$1,112.20
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% = \$1,312.40
60012	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 1 to 3 data acquisition runs (R) (Anaes.) Fee: \$564.00 Benefit: 75% = \$423.00 85% = \$500.10
60015	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 4 to 6 data acquisition runs (R) (Anaes.) Fee: \$827.10 Benefit: 75% = \$620.35 85% = \$763.20
60018	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 7 to 9 data acquisition runs (R) (Anaes.) Fee: \$1,176.10 Benefit: 75% = \$882.10 85% = \$1,112.20
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% = \$1,312.40

DIAGNOSTIC RADIOLOGY		TOMOGRAPHY
60024	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 1 to 3 data acquisition runs (R) (Anaes.) Fee: \$564.00 Benefit: 75% = \$423.00 85% = \$500.10	
60027	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 4 to 6 data acquisition runs (R) (Anaes.) Fee: \$827.10 Benefit: 75% = \$620.35 85% = \$763.20	
60030	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 7 to 9 data acquisition runs (R) (Anaes.) Fee: \$1,176.10 Benefit: 75% = \$882.10 85% = \$1,112.20	
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% = \$1,312.40	
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% = \$500.10	
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% = \$763.20	
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% = \$1,112.20	
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% = \$1,312.40	
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% = \$500.10	
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% = \$763.20	
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% = \$1,112.20	
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% = \$1,312.40	
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% = \$500.10	
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% = \$763.20	
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% = \$1,112.20	
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% = \$1,312.40	
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	

DIAGNOSTIC RADIOLOGY		FLUOROSCOPIC EXAMINATION
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	

NUCLEAR MEDICINE IMAGING		NUCLEAR MEDICINE IMAGING	
GROUP I4 - NUCLEAR MEDICINE IMAGING			
61302	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) Fee: \$448.85 Benefit: 75% = \$336.65 85% = \$384.95		
61303	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission tomography and with planar imaging when undertaken (R) Fee: \$565.30 Benefit: 75% = \$424.00 85% = \$501.40		
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: \$709.70 Benefit: 75% = \$532.30 85% = \$645.80		
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: \$834.90 Benefit: 75% = \$626.20 85% = \$771.00		
61310	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) Fee: \$367.30 Benefit: 75% = \$275.50 85% = \$312.25		
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: \$303.35 Benefit: 75% = \$227.55 85% = \$257.85		
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: \$420.00 Benefit: 75% = \$315.00 85% = \$357.00		
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: \$381.15 Benefit: 75% = \$285.90 85% = \$324.00		
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: \$492.40 Benefit: 75% = \$369.30 85% = \$428.50		
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: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60		
61328	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) Fee: \$227.65 Benefit: 75% = \$170.75 85% = \$193.55		
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: \$253.00 Benefit: 75% = \$189.75 85% = \$215.05		
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: \$443.35 Benefit: 75% = \$332.55 85% = \$379.45		
61352	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) Fee: \$259.35 Benefit: 75% = \$194.55 85% = \$220.45		
61353	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) Fee: \$386.60 Benefit: 75% = \$289.95 85% = \$328.65		
61356	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) Fee: \$392.80 Benefit: 75% = \$294.60 85% = \$333.90		
61360	HEPATOBIILIARY STUDY, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R) Fee: \$403.35 Benefit: 75% = \$302.55 85% = \$342.85		

NUCLEAR MEDICINE IMAGING		NUCLEAR MEDICINE IMAGING	
61361	HEPATOBIILIARY STUDY with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R) Fee: \$461.40 Benefit: 75% = \$346.05 85% = \$397.50		
61364	BOWEL HAEMORRHAGE STUDY (R) Fee: \$496.95 Benefit: 75% = \$372.75 85% = \$433.05		
61368	MECKEL'S DIVERTICULUM STUDY (R) Fee: \$223.10 Benefit: 75% = \$167.35 85% = \$189.65		
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: \$2,015.75 Benefit: 75% = \$1,511.85 85% = \$1,951.85		
61372	SALIVARY STUDY (R) Fee: \$223.10 Benefit: 75% = \$167.35 85% = \$189.65		
61373	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) Fee: \$489.70 Benefit: 75% = \$367.30 85% = \$425.80		
61376	OESOPHAGEAL CLEARANCE STUDY (R) Fee: \$143.35 Benefit: 75% = \$107.55 85% = \$121.85		
61381	GASTRIC EMPTYING STUDY, using single tracer (R) Fee: \$574.35 Benefit: 75% = \$430.80 85% = \$510.45		
61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) Fee: \$624.95 Benefit: 75% = \$468.75 85% = \$561.05		
61384	RADIONUCLIDE COLONIC TRANSIT STUDY (R) Fee: \$687.70 Benefit: 75% = \$515.80 85% = \$623.80		
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) Fee: \$332.50 Benefit: 75% = \$249.40 85% = \$282.65		
61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) Fee: \$430.75 Benefit: 75% = \$323.10 85% = \$366.85		
61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) Fee: \$370.55 Benefit: 75% = \$277.95 85% = \$315.00		
61390	RENAL STUDY with diuretic administration following a baseline study (R) Fee: \$409.95 Benefit: 75% = \$307.50 85% = \$348.50		
61393	COMBINED EXAMINATION INVOLVING A RENAL STUDY following angiotensin converting enzyme (ACE) inhibitor provocation and a baseline study, in either order and related to a single referral episode (R) Fee: \$605.50 Benefit: 75% = \$454.15 85% = \$541.60		
61397	CYSTOURETEROGRAM (R) Fee: \$246.85 Benefit: 75% = \$185.15 85% = \$209.85		
61401	TESTICULAR STUDY (R) Fee: \$162.30 Benefit: 75% = \$121.75 85% = \$138.00		
61402	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) Fee: \$605.05 Benefit: 75% = \$453.80 85% = \$541.15		
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: \$346.00 Benefit: 75% = \$259.50 85% = \$294.10		
61409	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) Fee: \$873.50 Benefit: 75% = \$655.15 85% = \$809.60		

NUCLEAR MEDICINE IMAGING		NUCLEAR MEDICINE IMAGING	
61413	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) Fee: \$225.95 Benefit: 75% = \$169.50 85% = \$192.10		
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: \$118.85 Benefit: 75% = \$89.15 85% = \$101.05		
61421	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Fee: \$479.80 Benefit: 75% = \$359.85 85% = \$415.90		
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: \$600.70 Benefit: 75% = \$450.55 85% = \$536.80		
61426	WHOLE BODY STUDY using iodine (R) Fee: \$554.80 Benefit: 75% = \$416.10 85% = \$490.90		
61429	WHOLE BODY STUDY using gallium (R) Fee: \$543.00 Benefit: 75% = \$407.25 85% = \$479.10		
61430	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) Fee: \$659.45 Benefit: 75% = \$494.60 85% = \$595.55		
61433	WHOLE BODY STUDY using cells labelled with technetium (R) Fee: \$496.95 Benefit: 75% = \$372.75 85% = \$433.05		
61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) Fee: \$615.40 Benefit: 75% = \$461.55 85% = \$551.50		
61437	WHOLE BODY STUDY using thallium (R) Fee: \$542.75 Benefit: 75% = \$407.10 85% = \$478.85		
61438	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) Fee: \$672.95 Benefit: 75% = \$504.75 85% = \$609.05		
61441	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) Fee: \$489.70 Benefit: 75% = \$367.30 85% = \$425.80		
61442	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (R) Fee: \$752.35 Benefit: 75% = \$564.30 85% = \$688.45		
61445	BONE MARROW STUDY - localised using technetium labelled agent (R) Fee: \$286.80 Benefit: 75% = \$215.10 85% = \$243.80		
61446	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) Fee: \$333.55 Benefit: 75% = \$250.20 85% = \$283.55		
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: \$456.20 Benefit: 75% = \$342.15 85% = \$392.30		
61450	LOCALISED STUDY using gallium (R) Fee: \$397.55 Benefit: 75% = \$298.20 85% = \$337.95		
61453	LOCALISED STUDY using gallium, with single photon emission tomography (R) Fee: \$514.70 Benefit: 75% = \$386.05 85% = \$450.80		
61454	LOCALISED STUDY using cells labelled with technetium (R) Fee: \$348.10 Benefit: 75% = \$261.10 85% = \$295.90		
61457	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) Fee: \$470.45 Benefit: 75% = \$352.85 85% = \$406.55		
61458	LOCALISED STUDY using thallium (R) Fee: \$396.95 Benefit: 75% = \$297.75 85% = \$337.45		

NUCLEAR MEDICINE IMAGING		NUCLEAR MEDICINE IMAGING	
61461	LOCALISED STUDY using thallium, with single photon emission tomography (R) Fee: \$527.85 Benefit: 75% = \$395.90 85% = \$463.95		
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: \$265.50 Benefit: 75% = \$199.15 85% = \$225.70		
61469	LYMPHOSCINTIGRAPHY (R) Fee: \$348.10 Benefit: 75% = \$261.10 85% = \$295.90		
61473	THYROID STUDY including uptake measurement when undertaken (R) Fee: \$175.40 Benefit: 75% = \$131.55 85% = \$149.10		
61480	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) Fee: \$386.85 Benefit: 75% = \$290.15 85% = \$328.85		
61484	ADRENAL STUDY, with imaging on 2 or more separate occasions (R) Fee: \$880.85 Benefit: 75% = \$660.65 85% = \$816.95		
61485	ADRENAL STUDY, with imaging on 2 or more occasions and renal localisation and single photon emission tomography when undertaken (R) Fee: \$999.20 Benefit: 75% = \$749.40 85% = \$935.30		
61495	TEAR DUCT STUDY (R) Fee: \$223.10 Benefit: 75% = \$167.35 85% = \$189.65		
61499	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) Fee: \$253.00 Benefit: 75% = \$189.75 85% = \$215.05		
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 <i>ex-vivo WBC scanning</i> . (Ministerial Determination) <i>Note</i> 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: \$878.70 Benefit: 75% = \$659.05 85% = \$814.80		

MAGNETIC RESONANCE IMAGING		MRI
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 dissection (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	

MAGNETIC RESONANCE IMAGING		MRI
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 vessels for:	
63101	- stroke (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$428.90	
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% = \$428.90	
63114	- inflammation of the central nervous system or meninges (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$428.90	
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% = \$428.90	
63128	- congenital malformation of the central nervous system or meninges (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$428.90	
63131	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$428.90	
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	

MAGNETIC RESONANCE IMAGING		MRI
63167	myelopathy (R) (Contrast) (Anaes.) Fee: \$358.40 Benefit: 75% = \$268.80 85% = \$304.65	
63170	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.) Fee: \$358.40 Benefit: 75% = \$268.80 85% = \$304.65	
63173	- cervical radiculopathy (R) (Contrast) (Anaes.) Fee: \$358.40 Benefit: 75% = \$268.80 85% = \$304.65	
63176	- sciatica (R) (Contrast) (Anaes.) Fee: \$358.40 Benefit: 75% = \$268.80 85% = \$304.65	
63179	- spinal canal stenosis (R) (Contrast) (Anaes.) Fee: \$358.40 Benefit: 75% = \$268.80 85% = \$304.65	
63182	- previous spinal surgery (R) (Contrast) (Anaes.) Fee: \$358.40 Benefit: 75% = \$268.80 85% = \$304.65	
63185	- trauma (R) (Anaes.) 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:		
63201	- infection (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
63204	- tumour (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
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:		
63219	- demyelinating disease (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
63222	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
63225	- myelopathy (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
63228	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
63231	- cervical radiculopathy (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
63234	- sciatica (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
63237	- spinal canal stenosis (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
63240	- previous spinal surgery (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	

MAGNETIC RESONANCE IMAGING		MRI
63243	- trauma (R) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
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 cervical spine and brachial plexus for:		
63271	- tumour (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$428.90	
63274	- trauma (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$428.90	
63277	- cervical radiculopathy (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$428.90	
63280	- previous surgery (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$428.90	
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:		
63301	- tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (R) (Contrast) (Anaes.) Fee: \$380.80 Benefit: 75% = \$285.60 85% = \$323.70	
63304	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (R) (Contrast) (Anaes.) Fee: \$380.80 Benefit: 75% = \$285.60 85% = \$323.70	
63307	- osteonecrosis (R) (Contrast) (Anaes.) 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:		
63322	- derangement of hip or its supporting structures (R) (Contrast) (Anaes.) Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	
63325	- derangement of shoulder or its supporting structures (R) (Contrast) (Anaes.) Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	
63328	- derangement of knee or its supporting structures (R) (Contrast) (Anaes.) Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	
63331	- derangement of ankle and/or foot or its supporting structures (R) (Contrast) (Anaes.) Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	
63334	- derangement of one or both temporomandibular joints or their supporting structures (R) (Contrast) (Anaes.) Fee: \$336.00 Benefit: 75% = \$252.00 85% = \$285.60	
63337	- derangement of wrist and/or hand or its supporting structures (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10	
63340	- derangement of elbow or its supporting structures (R) (Contrast) (Anaes.) Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	

MAGNETIC RESONANCE IMAGING		MRI
SUBGROUP 13 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS		
	<p>NOTE: Benefits are payable for each service included by Subgroup 13 on two occasions only in any 12 month period</p> <p>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:</p> <p>- Gaucher disease (R) (Anaes.)</p>	
63361	<p>Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75</p>	
SUBGROUP 14 - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS		
	<p>NOTE: Benefits are payable for each service included by Subgroup 14 on two occasions only in any 12 month period</p> <p>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:</p> <p>- congenital disease of the heart or a great vessel (R) (Contrast) (Anaes.)</p>	
63385	<p>Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10</p>	
63388	<p>- tumour of the heart or a great vessel (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$384.10</p>	
63391	<p>- abnormality of thoracic aorta (R) (Contrast) (Anaes.) Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75</p>	
SUBGROUP 15 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS		
	<p>NOTE: Benefits are payable for each service included by Subgroup 15 on three occasions only in any 12 month period</p> <p>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:</p> <p>- vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.)</p>	
63401	<p>Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75</p>	
63404	<p>- 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</p>	
63405	<p>MRA - if the request for the scan specifically identifies the clinical indication for the scan - scan of cardiovascular system for obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75</p>	
SUBGROUP 16 - MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS		
	<p>NOTE: Benefits are payable for each service included by Subgroup 16 on one occasion only in any 12 month period</p> <p>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:</p> <p>- the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Contrast) (Anaes.)</p>	
63416	<p>Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75</p>	
SUBGROUP 17 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS		
	<p>NOTE: Benefits are payable for each service included by Subgroup 17 on two occasions only in any 12 month period, for previously diagnosed conditions</p> <p>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:</p> <p>- post-inflammatory or post-traumatic physéal fusion (R) (Anaes.)</p>	
63425	<p>Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75</p>	

MAGNETIC RESONANCE IMAGING		MRI
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 resectable (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% = \$563.30	
SUBGROUP 21 - SCAN OF BODY - FOR SPECIFIED CONDITIONS		
63482	NOTE: Benefits are only payable for each service included by Subgroup 21 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 pancreas and biliary tree for: - suspected biliary or pancreatic pathology (R) (Contrast) (Anaes.) Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	

MAGNETIC RESONANCE IMAGING		MRI
SUBGROUP 22 - MODIFYING ITEMS		
	<p>NOTE: Benefits in Subgroup 22 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.</p> <p>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:</p> <p>- involves the use of contrast agent for eligible Magnetic Resonance Imaging items (Note: (Contrast) denotes an item eligible for use with this item)</p>	
63491	<p>Fee: \$44.80 Benefit: 75% = \$33.60 85% = \$38.10</p>	
63494	<p>- involves use of intravenous or intramuscular sedation on a patient</p> <p>Fee: \$44.80 Benefit: 75% = \$33.60 85% = \$38.10</p>	
63497	<p>- on a patient under anaesthetic in the presence of a medical practitioner qualified to perform an anaesthetic</p> <p>Fee: \$156.80 Benefit: 75% = \$117.60 85% = \$133.30</p>	

GROUP I6 - MANAGEMENT OF BULK-BILLED SERVICES	
64990	<p>A diagnostic imaging service to which an item in this table (other than this item or item 64991) applies if:</p> <ul style="list-style-type: none"> (a) the service is an unreferral 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: <ul style="list-style-type: none"> (i) this item; and (ii) the other item in this table applying to the service <p>Fee: \$6.20 Benefit: 85% = \$5.30</p>
64991	<p>A diagnostic imaging service to which an item in this table (other than this item or item 64990) applies if:</p> <ul style="list-style-type: none"> (a) the service is an unreferral 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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) A geographical area included in any of the following SSD spatial units: <ul style="list-style-type: none"> (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) <p>Fee: \$9.40 Benefit: 85% = \$8.00</p>

CATEGORY 6 - PATHOLOGY SERVICES

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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, 69365 or 69367 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, 69365 or 69367.

- (d) That is specified in item 73320, HLA-B27 typing by nucleic acid amplification, and is considered necessary by the specialist pathologist because the results of HLA-B27 typing described in item 71147 are unsatisfactory.

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 control estimation, repeat tests (eg. for confirmation of earlier tests on the same specimen, etc);
- preparation of autogenous vaccines;
- 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 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 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 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: MSAC Secretariat, Australian Government, Department of Health and Ageing, MDP 106, 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 Items referring to the ‘detection of’

Items that contain the term ‘detection of’ should be taken to mean ‘testing for the presence of’.

PP.2 Blood Grouping (Item 65096)

Where a request includes 'Group and Hold' or 'Group and Save', the appropriate item is 65096.

PP.3 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.4 Iron Studies (Item 66596)

Where a request includes 'Iron Studies', 'IS', 'Fe', '% saturation' or 'Iron', the relevant item is 66596.

PP.5 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.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 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.

PP.8 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.9 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.10 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.11 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.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 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 unreferral pathology services performed by a medical practitioner which are included in Group P9 of the Pathology Services Table, and unreferral 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.14 Transfer of existing items from Group P1 (Haematology) to Group P7 Genetics effective 1 May 2006.

PP.14 has been created to note the transfer of existing items from Group P1 (Haematology) items 65168, 65174, 65200 and item 66794 from Group P2 (Chemistry) to Group P7 (Genetics) as items 73308, 73311, 73314, 73317 and the introduction of the new item in Group P7 (Genetics) item 73320 HLA-B27 typing by nucleic acid amplification (NAA) which was effective as of 1 May 2006.

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 isoenzymes, Myoglobin, Troponin	CE / CM	66518, 66519
Coagulation studies	Full blood count, Prothrombin time, Activated partial thromboplastin time and two or more of the following tests – Fibrinogen, Thrombin, Clotting time, Fibrinogen degradation products, Fibrin monomer, D-dimer factor XIII screening tests	COAG	65129, 65070
Electrolytes	Sodium (NA), Potassium (K), Chloride (CL) and Bicarbonate (HCO ₃)	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),	LFT	66515

Group	Estimations included in Group	Group Abbreviation	Item Numbers
	Lactate dehydrogenase (LDH), and Protein (PROT)		
Syphilis serology	Rapid plasma regain test (RPR), or Venereal disease research laboratory test (VDRL), and Treponema pallidum haemagglutinin test (TPHA), or Fluorescent treponemal antibody-absorption test (FTA)	STS	69387
Urea, Electrolytes, Creatinine	Urea, Electrolytes, Creatinine	U&E	66515

PR. COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

PR.1 Complexity Levels

Only one of these histopathology examination items (72813, 72816, 72817, 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, 3DB or 3E 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 RRMA 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;
 - (h) quantitative estimation of calcium, phosphate, magnesium, urea, creatinine and electrolytes in cancer patients receiving bisphosphonate infusions.
- if:
- (i) 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
 - (ii) the tests are performed within 6 months of the request; and
 - (iii) 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.

specimen collection centre has the same meaning as in Part IIA of the Act.

treating practitioner has the same meaning as in paragraph 16A(1)(a) of the Act.

14. (2) If a service described in an item in Group P10 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, 69365 or 69367 is a pathologist determinable service the specialist pathologist is required to record the reasons for determining the need for this service.
27. If the service rendered in 73320 is a pathologist determinable service, the specialist pathologist is required to record the reason for determining the need for this service including the result of the service in 71147.

PATHOLOGY	PATHOLOGY
GROUP P1 - HAEMATOLOGY	
65060	Haemoglobin, erythrocyte sedimentation rate, blood viscosity - 1 or more tests Fee: \$7.95 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: \$52.90 Benefit: 75% = \$39.70 85% = \$45.00
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: \$91.75 Benefit: 75% = \$68.85 85% = \$78.00
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: \$98.25 Benefit: 75% = \$73.70 85% = \$83.55
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: \$168.75 Benefit: 75% = \$126.60 85% = \$143.45
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: \$84.55 Benefit: 75% = \$63.45 85% = \$71.90

PATHOLOGY	PATHOLOGY
65090	Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen) Fee: \$11.25 Benefit: 75% = \$8.45 85% = \$9.60
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: \$22.35 Benefit: 75% = \$16.80 85% = \$19.00
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: \$41.65 Benefit: 75% = \$31.25 85% = \$35.45
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: \$113.40 Benefit: 75% = \$85.05 85% = \$96.40
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: \$170.10 Benefit: 75% = \$127.60 85% = \$144.60
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: \$113.40 Benefit: 75% = \$85.05 85% = \$96.40
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: \$170.10 Benefit: 75% = \$127.60 85% = \$144.60
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: \$20.60 Benefit: 75% = \$15.45 85% = \$17.55
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: \$14.05 Benefit: 75% = \$10.55 85% = \$11.95
65123	2 tests described in item 65120 Fee: \$20.60 Benefit: 75% = \$15.45 85% = \$17.55
65126	3 tests described in item 65120 Fee: \$28.35 Benefit: 75% = \$21.30 85% = \$24.10

PATHOLOGY		PATHOLOGY
65129	4 or more tests described in item 65120 Fee: \$36.10 Benefit: 75% = \$27.10 85% = \$30.70	
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: \$25.75 Benefit: 75% = \$19.35 85% = \$21.90	
65133	2 tests described in item 65132 Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
65134	3 tests described in item 65132 Fee: \$73.20 Benefit: 75% = \$54.90 85% = \$62.25	
65135	4 tests described in item 65132 Fee: \$96.90 Benefit: 75% = \$72.70 85% = \$82.40	
65136	5 tests described in item 65132 Fee: \$120.65 Benefit: 75% = \$90.50 85% = \$102.60	
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: \$25.75 Benefit: 75% = \$19.35 85% = \$21.90	
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: \$25.75 Benefit: 75% = \$19.35 85% = \$21.90	
65144	Platelet aggregation in response to ADP, collagen, 5HT, ristocetin or other substances; or heparin, low molecular weight heparins, heparinoid or other drugs - 1 or more tests Fee: \$57.55 Benefit: 75% = \$43.20 85% = \$48.95	
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test Fee: \$38.55 Benefit: 75% = \$28.95 85% = \$32.80	
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: \$72.15 Benefit: 75% = \$54.15 85% = \$61.35	
65153	2 tests described in item 65150 Fee: \$144.35 Benefit: 75% = \$108.30 85% = \$122.70	
65156	3 or more tests described in item 65150 Fee: \$216.50 Benefit: 75% = \$162.40 85% = \$184.05	
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test Fee: \$72.15 Benefit: 75% = \$54.15 85% = \$61.35	
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test) Fee: \$10.55 Benefit: 75% = \$7.95 85% = \$9.00	
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: \$35.05 Benefit: 75% = \$26.30 85% = \$29.80	
65171	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above - 1 or more tests Fee: \$25.75 Benefit: 75% = \$19.35 85% = \$21.90	

PATHOLOGY	PATHOLOGY
GROUP P2 - CHEMICAL	
66500	Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter) of: acetoacetate, acid phosphatase, alanine aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, beta-hydroxybutyrate, bicarbonate, bilirubin (total), bilirubin (any fractions), C-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, pyruvate, sodium, total protein, total cholesterol, triglycerides, urate or urea - 1 test Fee: \$9.75 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: \$31.15 Benefit: 75% = \$23.40 85% = \$26.50
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: \$19.30 Benefit: 75% = \$14.50 85% = \$16.45
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: \$16.10 Benefit: 75% = \$12.10 85% = \$13.70
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% = \$15.25 85% = \$17.30
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: \$17.10 Benefit: 75% = \$12.85 85% = \$14.55
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: \$17.10 Benefit: 75% = \$12.85 85% = \$14.55

PATHOLOGY		PATHOLOGY	
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% = \$7.40	85% = \$8.40
66560	Microalbumin - quantitation in urine Fee: \$20.50	Benefit: 75% = \$15.40	85% = \$17.45
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests Fee: \$25.10	Benefit: 75% = \$18.85	85% = \$21.35
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: \$18.35	Benefit: 75% = \$13.80	85% = \$15.60
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin Fee: \$33.10	Benefit: 75% = \$24.85	85% = \$28.15
66599	Serum B12 or red cell folate and, if required, serum folate (Item is subject to rule 21) Fee: \$24.05	Benefit: 75% = \$18.05	85% = \$20.45
66602	Serum B12 and red cell folate and, if required, serum folate (Item is subject to rule 21) Fee: \$43.75	Benefit: 75% = \$32.85	85% = \$37.20
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: \$31.15	Benefit: 75% = \$23.40	85% = \$26.50
66608	Vitamin D or D fractions - 1 or more tests Fee: \$43.00	Benefit: 75% = \$32.25	85% = \$36.55

PATHOLOGY		PATHOLOGY	
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: \$42.25	Benefit: 75% = \$31.70 85% = \$35.95
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: \$24.55	Benefit: 75% = \$18.45 85% = \$20.90
66629	Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests	Fee: \$20.50	Benefit: 75% = \$15.40 85% = \$17.45
66632	Caeruloplasmin, haptoglobins, or prealbumin - quantitation in serum, urine or other body fluids - 1 or more tests	Fee: \$20.50	Benefit: 75% = \$15.40 85% = \$17.45
66635	Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests	Fee: \$20.50	Benefit: 75% = \$15.40 85% = \$17.45
66638	Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum - 1 or more tests	Fee: \$29.70	Benefit: 75% = \$22.30 85% = \$25.25
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: \$29.70	Benefit: 75% = \$22.30 85% = \$25.25
66644	C-1 esterase inhibitor - quantitation	Fee: \$20.50	Benefit: 75% = \$15.40 85% = \$17.45
66647	C-1 esterase inhibitor - functional assay	Fee: \$45.90	Benefit: 75% = \$34.45 85% = \$39.05
66650	Alpha-fetoprotein, CA-15.3 antigen (CA15.3), CA-125 antigen (CA125), CA-19.9 antigen (CA19.9), cancer associated serum antigen (CASA), carcinoembryonic antigen (CEA), human chorionic gonadotrophin (HCG), mammary serum antigen (MSA), thyroglobulin in serum or other body fluid, in the monitoring of malignancy or in the detection or monitoring of hepatic tumours, gestational trophoblastic disease or germ cell tumour - quantitation - 1 test	Fee: \$24.75	Benefit: 75% = \$18.60 85% = \$21.05
66653	2 or more tests described in item 66650	Fee: \$45.35	Benefit: 75% = \$34.05 85% = \$38.55
66655	Prostate specific antigen - quantitation - 1 of this item in a 12 month period	Fee: \$20.50	Benefit: 75% = \$15.40 85% = \$17.45
66656	Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655)	Fee: \$20.50	Benefit: 75% = \$15.40 85% = \$17.45
66659	Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the followup of a PSA result which lies in the equivocal range of the particular method of assay used to determine the level - 1 of this item in a 12 month period	Fee: \$37.80	Benefit: 75% = \$28.35 85% = \$32.15
66662	Quantitation of hormone receptors on proven primary breast or ovarian carcinoma or a metastasis from a breast or ovarian carcinoma or a subsequent lesion in the breast - 1 or more tests	Fee: \$81.35	Benefit: 75% = \$61.05 85% = \$69.15
66665	Lead quantitation in blood or urine (other than for occupational health screening purposes) to a maximum of 3 tests in a 6 month period - each test	Fee: \$31.15	Benefit: 75% = \$23.40 85% = \$26.50

PATHOLOGY	PATHOLOGY
66667	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test Fee: \$31.15 Benefit: 75% = \$23.40 85% = \$26.50
66669	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22) Fee: \$31.15 Benefit: 75% = \$23.40 85% = \$26.50
66670	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 2 or more tests. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22) Fee: \$53.35 Benefit: 75% = \$40.05 85% = \$45.35
66671	Quantitation of serum aluminium in a patient in a renal dialysis program - each test Fee: \$37.55 Benefit: 75% = \$28.20 85% = \$31.95
66672	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22) Fee: \$31.15 Benefit: 75% = \$23.40 85% = \$26.50
66673	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 2 or more tests. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22) Fee: \$53.35 Benefit: 75% = \$40.05 85% = \$45.35
66674	Quantitation of: (a) faecal fat; or (b) breath hydrogen in response to loading with disaccharides; 1 or more tests within a 28 day period Fee: \$40.65 Benefit: 75% = \$30.50 85% = \$34.60
66677	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old Fee: \$11.35 Benefit: 75% = \$8.55 85% = \$9.65
66680	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests Fee: \$75.75 Benefit: 75% = \$56.85 85% = \$64.40
66683	Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests Fee: \$75.75 Benefit: 75% = \$56.85 85% = \$64.40
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: \$30.70 Benefit: 75% = \$23.05 85% = \$26.10
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: \$43.80 Benefit: 75% = \$32.85 85% = \$37.25

PATHOLOGY		PATHOLOGY	
66701	<p>3 tests described in item 66695</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA)</p> <p>(Item is subject to rule 6)</p>	Fee: \$57.20	Benefit: 75% = \$42.90 85% = \$48.65
66704	<p>4 tests described in item 66695</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA)</p> <p>(Item is subject to rule 6)</p>	Fee: \$70.60	Benefit: 75% = \$52.95 85% = \$60.05
66707	<p>5 tests described in item 66695</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA)</p> <p>(Item is subject to rule 6)</p>	Fee: \$84.05	Benefit: 75% = \$63.05 85% = \$71.45
66710	<p>6 or more tests described in item 66695</p> <p>(Item is subject to rule 6)</p>	Fee: \$97.45	Benefit: 75% = \$73.10 85% = \$82.85
66711	<p>Quantitation in saliva of cortisol in:</p> <p>(a) the investigation of Cushing's syndrome; or</p> <p>(b) the management of children with congenital adrenal hyperplasia</p>	Fee: \$30.70	Benefit: 75% = \$23.05 85% = \$26.10
66712	<p>Two tests described in item 66711</p>	Fee: \$43.80	Benefit: 75% = \$32.85 85% = \$37.25
66713	<p>Tests described in item 66695, if rendered under a request referred to in subparagraph (2)(a)(iii) of rule 6 - each test to a maximum of 5 tests</p> <p>(Item is subject to rule 6)</p>	Fee: \$13.40	Benefit: 75% = \$10.05 85% = \$11.40
66716	<p>TSH quantitation</p>	Fee: \$25.45	Benefit: 75% = \$19.10 85% = \$21.65
66719	<p>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:</p> <p>(a) the patient has an abnormal level of TSH;</p> <p>(b) the tests are performed:</p> <p>(i) for the purpose of monitoring thyroid disease in the patient; or</p> <p>(ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or</p> <p>(iii) to investigate dementia or psychiatric illness of the patient; or</p> <p>(iv) to investigate amenorrhoea or infertility of the patient;</p> <p>(c) the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction;</p> <p>(d) the patient is on drugs that interfere with thyroid hormone metabolism or function</p> <p>(Item is subject to rule 9)</p>	Fee: \$35.45	Benefit: 75% = \$26.60 85% = \$30.15
66722	<p>TSH quantitation described in item 66716 and 1 test described in item 66695</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA)</p> <p>(Item is subject to rule 6)</p>	Fee: \$38.55	Benefit: 75% = \$28.95 85% = \$32.80

PATHOLOGY		PATHOLOGY	
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: \$51.95	Benefit: 75% = \$39.00 85% = \$44.20
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: \$65.35	Benefit: 75% = \$49.05 85% = \$55.55
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: \$78.75	Benefit: 75% = \$59.10 85% = \$66.95
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: \$92.15	Benefit: 75% = \$69.15 85% = \$78.35
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: \$13.40	Benefit: 75% = \$10.05 85% = \$11.40
66743	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751	Fee: \$20.50	Benefit: 75% = \$15.40 85% = \$17.45
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: \$25.10	Benefit: 75% = \$18.85 85% = \$21.35
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: \$25.10	Benefit: 75% = \$18.85 85% = \$21.35
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

PATHOLOGY		PATHOLOGY	
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.5 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: \$25.10	Benefit: 75% = \$18.85 85% = \$21.35
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	Porphyryns or porphyryns precursors - detection in plasma, red cells, urine or faeces - 1 or more tests	Fee: \$13.40	Benefit: 75% = \$10.05 85% = \$11.40
66785	Porphyryns or porphyryns precursors - quantitation in plasma, red cells, urine or faeces - 1 test	Fee: \$40.65	Benefit: 75% = \$30.50 85% = \$34.60
66788	Porphyryns or porphyryns precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests	Fee: \$67.00	Benefit: 75% = \$50.25 85% = \$56.95
66791	Porphyryn 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
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.6 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

PATHOLOGY	PATHOLOGY
66812	<p>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</p> <p>(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) <i>(See para PP.6 of explanatory notes to this Category)</i></p> <p>Fee: \$35.45 Benefit: 75% = \$26.60 85% = \$30.15</p>
66815	<p>2 tests described in item 66812</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)</p> <p>Fee: \$60.60 Benefit: 75% = \$45.45 85% = \$51.55</p>
66818	<p>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)</p> <p>Fee: \$25.15 Benefit: 75% = \$18.90 85% = \$21.40</p>

PATHOLOGY	PATHOLOGY
GROUP P3 - MICROBIOLOGY	
69300	<p>Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including:</p> <p>(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</p> <p>Fee: \$12.60 Benefit: 75% = \$9.45 85% = \$10.75</p>
69303	<p>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):</p> <p>(a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300; specimens from 1 or more sites</p> <p>Fee: \$22.15 Benefit: 75% = \$16.65 85% = \$18.85</p>
69306	<p>Microscopy and culture to detect pathogenic micro-organisms from skin or other superficial sites, including (if performed):</p> <p>(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</p> <p>Fee: \$34.00 Benefit: 75% = \$25.50 85% = \$28.90</p>
69309	<p>Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed):</p> <p>(a) the detection of antigens not elsewhere specified in this Table; or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens</p> <p>Fee: \$48.45 Benefit: 75% = \$36.35 85% = \$41.20</p>
69312	<p>Microscopy and culture to detect pathogenic micro-organisms from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed):</p> <p>(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</p> <p>Fee: \$34.00 Benefit: 75% = \$25.50 85% = \$28.90</p>
69318	<p>Microscopy and culture to detect pathogenic micro-organisms from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed):</p> <p>(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</p> <p>Fee: \$34.00 Benefit: 75% = \$25.50 85% = \$28.90</p>
69321	<p>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):</p> <p>(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</p> <p>Fee: \$48.45 Benefit: 75% = \$36.35 85% = \$41.20</p>
69324	<p>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):</p> <p>(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</p> <p>Fee: \$43.30 Benefit: 75% = \$32.50 85% = \$36.85</p>
69327	<p>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):</p> <p>(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</p> <p>Fee: \$85.55 Benefit: 75% = \$64.20 85% = \$72.75</p>

PATHOLOGY		PATHOLOGY	
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: \$128.85	Benefit: 75% = \$96.65 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 susceptibility testing; and (g) (if performed) examination for pH, specific gravity, blood, albumin, urobilinogen, sugar, acetone or bile salts	Fee: \$20.70	Benefit: 75% = \$15.55 85% = \$17.60
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% = \$25.25 85% = \$28.65
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: \$19.25	Benefit: 75% = \$14.45 85% = \$16.40
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: \$53.25	Benefit: 75% = \$39.95 85% = \$45.30
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% = \$23.25 85% = \$26.35
69357	2 sets of cultures described in item 69354	Fee: \$61.85	Benefit: 75% = \$46.40 85% = \$52.60
69360	3 sets of cultures described in item 69354	Fee: \$92.80	Benefit: 75% = \$69.60 85% = \$78.90
69363	Detection of <i>Clostridium difficile</i> or <i>Clostridium difficile</i> toxin (except if a service described in items 69345, 69369, 69370, 69373 or 69375 has been performed) - 1 or more tests	Fee: \$28.85	Benefit: 75% = \$21.65 85% = \$24.55
69364	Detection of a virus or microbial antigen or microbial nucleic acid (not elsewhere specified) 1 test (Item is subject to rule 26)	Fee: \$28.85	Benefit: 75% = \$21.65 85% = \$24.55
‡ 69365	2 tests described in 69364 (Item is subject to rule 26)	Fee: \$36.10	Benefit: 75% = \$27.10 85% = \$30.70
† 69367	3 or more tests described in 69364 (Item is subject to rule 26)	Fee: \$43.35	Benefit: 75% = \$32.55 85% = \$36.85

PATHOLOGY	PATHOLOGY
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: \$181.45 Benefit: 75% = \$136.10 85% = \$154.25
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: \$181.45 Benefit: 75% = \$136.10 85% = \$154.25
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: \$181.45 Benefit: 75% = \$136.10 85% = \$154.25
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) <i>(See para PP.7 and PP.13 of explanatory notes to this Category)</i> Fee: \$15.75 Benefit: 75% = \$11.85 85% = \$13.40
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) <i>(See para PP.7 and PP.13 of explanatory notes to this Category)</i> Fee: \$28.85 Benefit: 75% = \$21.65 85% = \$24.55
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) <i>(See para PP.7 and PP.13 of explanatory notes to this Category)</i> Fee: \$43.30 Benefit: 75% = \$32.50 85% = \$36.85
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) <i>(See para PP.7 and PP.13 of explanatory notes to this Category)</i> Fee: \$57.75 Benefit: 75% = \$43.35 85% = \$49.10
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) <i>(See para PP.7 and PP.13 of explanatory notes to this Category)</i> Fee: \$72.15 Benefit: 75% = \$54.15 85% = \$61.35
69399	6 or more tests described in item 69384 <i>(See para PP.7 and PP.13 of explanatory notes to this Category)</i> Fee: \$86.60 Benefit: 75% = \$64.95 85% = \$73.65
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) <i>(See para PP.13 of explanatory notes to this Category)</i> Fee: \$14.45 Benefit: 75% = \$10.85 85% = \$12.30

PATHOLOGY	PATHOLOGY
69405	<p>Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 1 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)</p> <p>Fee: \$15.75 Benefit: 75% = \$11.85 85% = \$13.40</p>
69408	<p>Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 2 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)</p> <p>Fee: \$28.00 Benefit: 75% = \$21.00 85% = \$23.80</p>
69411	<p>Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 3 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)</p> <p>Fee: \$39.35 Benefit: 75% = \$29.55 85% = \$33.45</p>
69413	<p>Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 4 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)</p> <p>Fee: \$50.65 Benefit: 75% = \$38.00 85% = \$43.10</p>
69415	<p>Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of all 5 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)</p> <p>Fee: \$61.95 Benefit: 75% = \$46.50 85% = \$52.70</p>
69442	<p>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</p> <p>Fee: \$181.45 Benefit: 75% = \$136.10 85% = \$154.25</p>
69443	<p>Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if:</p> <p>(a) the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis; and</p> <p>(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;</p> <p>To a maximum of 1 of this item in a 12 month period</p> <p>Fee: \$206.20 Benefit: 75% = \$154.65 85% = \$175.30</p>
69444	<p>Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied:</p> <p>(a) the patient is Hepatitis C seropositive;</p> <p>(b) the patient's serological status is uncertain after testing;</p> <p>(c) the test is performed for the purpose of:</p> <p>(i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or</p> <p>(ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient;</p> <p>To a maximum of 1 of this item in a 12 month period (Item is subject to rule 19)</p> <p>Fee: \$92.80 Benefit: 75% = \$69.60 85% = \$78.90</p>
69445	<p>Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69444) - 1 test. To a maximum of 4 of this item in a 12 month period (Item is subject to rule 19)</p> <p>Fee: \$92.80 Benefit: 75% = \$69.60 85% = \$78.90</p>

PATHOLOGY		PATHOLOGY	
69471	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 Fee: \$35.15	Benefit: 75% = \$26.40	85% = \$29.90
69472	Detection of antibodies to Epstein Barr Virus using specific serology - 1 test Fee: \$15.75	Benefit: 75% = \$11.85	85% = \$13.40
69474	Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests Fee: \$28.85	Benefit: 75% = \$21.65	85% = \$24.55
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: \$15.75	Benefit: 75% = \$11.85	85% = \$13.40
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: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
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) <i>(See para PP.8 of explanatory notes to this Category)</i> Fee: \$40.80	Benefit: 75% = \$30.60	85% = \$34.70
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: \$17.20	Benefit: 75% = \$12.90	85% = \$14.65
69486	A test for high risk human papillomaviruses (HPV) in a patient who: - has received excisional or ablative treatment for high grade squamous intraepithelial lesions (HSIL) 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 HSIL of the cervix; or - is already undergoing annual cytological review for the follow-up of a previously treated HSIL. - to a maximum of 2 of this item in a 24 month period Fee: \$64.00	Benefit: 75% = \$48.00	85% = \$54.40

PATHOLOGY	PATHOLOGY
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: \$51.40 Benefit: 75% = \$38.55 85% = \$43.70
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: \$29.70 Benefit: 75% = \$22.30 85% = \$25.25
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

PATHOLOGY		PATHOLOGY	
71085	2 tests described in item 71083 Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
71087	3 or more tests described in item 71083 Fee: \$38.35	Benefit: 75% = \$28.80	85% = \$32.60
71089	Quantitation of complement components or breakdown products of complement proteins not elsewhere described in an item in this Schedule - 1 test Fee: \$29.65	Benefit: 75% = \$22.25	85% = \$25.25
71091	2 tests described in item 71089 Fee: \$53.70	Benefit: 75% = \$40.30	85% = \$45.65
71093	3 or more tests described in item 71089 Fee: \$77.80	Benefit: 75% = \$58.35	85% = \$66.15
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.9 of explanatory notes to this Category) Fee: \$41.25	Benefit: 75% = \$30.95	85% = \$35.10
71097	Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required Fee: \$24.85	Benefit: 75% = \$18.65	85% = \$21.15
71099	Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method Fee: \$27.00	Benefit: 75% = \$20.25	85% = \$22.95
71101	Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids Fee: \$17.70	Benefit: 75% = \$13.30	85% = \$15.05
71103	Characterisation of an antibody detected in a service described in item 71101 (including that service) Fee: \$52.95	Benefit: 75% = \$39.75	85% = \$45.05
71106	Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required Fee: \$11.50	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: \$35.15	Benefit: 75% = \$26.40	85% = \$29.90
71113	Detection of 2 antibodies described in item 71109 Fee: \$48.25	Benefit: 75% = \$36.20	85% = \$41.05
71115	Detection of 3 antibodies described in item 71109 Fee: \$61.35	Benefit: 75% = \$46.05	85% = \$52.15
71117	Detection of 4 or more antibodies described in item 71109 Fee: \$74.45	Benefit: 75% = \$55.85	85% = \$63.30
71119	Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody Fee: \$17.65	Benefit: 75% = \$13.25	85% = \$15.05
71121	Detection of 2 antibodies specified in item 71119 Fee: \$21.15	Benefit: 75% = \$15.90	85% = \$18.00
71123	Detection of 3 antibodies specified in item 71119 Fee: \$24.65	Benefit: 75% = \$18.50	85% = \$21.00
71125	Detection of 4 or more antibodies specified in item 71119 Fee: \$28.15	Benefit: 75% = \$21.15	85% = \$23.95

PATHOLOGY		PATHOLOGY	
71127	<p>Functional tests for lymphocytes - quantitation other than by microscopy of:</p> <p>(a) proliferation induced by 1 or more mitogens; or</p> <p>(b) proliferation induced by 1 or more antigens; or</p> <p>(c) estimation of 1 or more mixed lymphocyte reactions;</p> <p>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</p>	Fee: \$179.45	Benefit: 75% = \$134.60 85% = \$152.55
71129	2 tests described in item 71127	Fee: \$221.65	Benefit: 75% = \$166.25 85% = \$188.45
71131	3 or more tests described in item 71127	Fee: \$263.90	Benefit: 75% = \$197.95 85% = \$224.35
71133	Investigation of recurrent infection by qualitative assessment for the presence of defects in oxidative pathways in neutrophils by the nitroblue tetrazolium (NBT) reduction test	Fee: \$10.55	Benefit: 75% = \$7.95 85% = \$9.00
71134	Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed)	Fee: \$105.85	Benefit: 75% = \$79.40 85% = \$90.00
71135	<p>Quantitation of neutrophil function, comprising at least 2 of the following:</p> <p>(a) chemotaxis;</p> <p>(b) phagocytosis;</p> <p>(c) oxidative metabolism;</p> <p>(d) bactericidal activity;</p> <p>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</p>	Fee: \$211.60	Benefit: 75% = \$158.70 85% = \$179.90
71137	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	Fee: \$30.80	Benefit: 75% = \$23.10 85% = \$26.20
71139	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations, including a total lymphocyte count or total leucocyte count by any method, on 1 or more specimens of blood, CSF or serous fluid	Fee: \$105.85	Benefit: 75% = \$79.40 85% = \$90.00
71141	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	Fee: \$200.85	Benefit: 75% = \$150.65 85% = \$170.75
71143	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	Fee: \$264.55	Benefit: 75% = \$198.45 85% = \$224.90
71145	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	Fee: \$431.95	Benefit: 75% = \$324.00 85% = \$368.05
71146	Enumeration of CD34+ cells, only for the purposes of autologous or directed allogeneic haemopoietic stem cell transplantation, including a total white cell count on the pheresis collection	Fee: \$105.85	Benefit: 75% = \$79.40 85% = \$90.00
71147	HLA-B27 typing	Fee: \$41.25	Benefit: 75% = \$30.95 85% = \$35.10
71149	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	Fee: \$110.15	Benefit: 75% = \$82.65 85% = \$93.65

PATHOLOGY		PATHOLOGY	
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: \$25.15	Benefit: 75% = \$18.90	85% = \$21.40
71164	Two or more tests described in 71163 and including a service described in 71066 (if performed) Fee: \$40.60	Benefit: 75% = \$30.45	85% = \$34.55

PATHOLOGY	PATHOLOGY
GROUP P5 - TISSUE PATHOLOGY	
72813	<p>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</p> <p>(Item is subject to rule 13) Fee: \$72.15 Benefit: 75% = \$54.15 85% = \$61.35</p>
72816	<p>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</p> <p>(Item is subject to rule 13) Fee: \$87.10 Benefit: 75% = \$65.35 85% = \$74.05</p>
72817	<p>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</p> <p>(Item is subject to rule 13) Fee: \$97.45 Benefit: 75% = \$73.10 85% = \$82.85</p>
72818	<p>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</p> <p>(Item is subject to rule 13) Fee: \$107.75 Benefit: 75% = \$80.85 85% = \$91.60</p>
72823	<p>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</p> <p>(Item is subject to rule 13) Fee: \$97.95 Benefit: 75% = \$73.50 85% = \$83.30</p>
72824	<p>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</p> <p>(Item is subject to rule 13) Fee: \$142.30 Benefit: 75% = \$106.75 85% = \$121.00</p>
72825	<p>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</p> <p>(Item is subject to rule 13) Fee: \$181.45 Benefit: 75% = \$136.10 85% = \$154.25</p>
72826	<p>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</p> <p>(Item is subject to rule 13) Fee: \$195.90 Benefit: 75% = \$146.95 85% = \$166.55</p>
72830	<p>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</p> <p>(Item is subject to rule 13) Fee: \$190.75 Benefit: 75% = \$143.10 85% = \$162.15</p>
72836	<p>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</p> <p>(Item is subject to rule 13) Fee: \$293.85 Benefit: 75% = \$220.40 85% = \$249.80</p>
72844	<p>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</p> <p>Fee: \$30.95 Benefit: 75% = \$23.25 85% = \$26.35</p>

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: \$185.60	Benefit: 75% = \$139.20 85% = \$157.80
72852	Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 13)	Fee: \$247.45	Benefit: 75% = \$185.60 85% = \$210.35
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: \$185.60	Benefit: 75% = \$139.20 85% = \$157.80
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: \$247.45	Benefit: 75% = \$185.60 85% = \$210.35
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: \$288.70	Benefit: 75% = \$216.55 85% = \$245.40

PATHOLOGY	PATHOLOGY
GROUP P6 - CYTOLOGY	
73043	<p>Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes 1 or more tests Fee: \$23.00 Benefit: 75% = \$17.25 85% = \$19.55</p>
73045	<p>Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73053); and including any Group P5 service, if performed on: (a) specimens resulting from washings or brushings from sites not specified in item 73043; or (b) a single specimen of sputum or urine; or (c) 1 or more specimens of other body fluids; 1 or more tests Fee: \$48.95 Benefit: 75% = \$36.75 85% = \$41.65</p>
73047	<p>Cytology of a series of 3 sputum or urine specimens for malignant cells Fee: \$95.35 Benefit: 75% = \$71.55 85% = \$81.05</p>
73049	<p>Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues Fee: \$69.60 Benefit: 75% = \$52.20 85% = \$59.20</p>
73051	<p>Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues if: (a) the aspiration is performed by a recognised pathologist; or (b) a recognised pathologist attends the aspiration and performs cytological examination during the attendance Fee: \$171.50 Benefit: 75% = \$128.65 85% = \$145.80</p>
73053	<p>Cytology of a smear from cervix where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each examination (a) for the detection of precancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia, or (b) if a further specimen is taken due to an unsatisfactory smear taken for the purposes of paragraph (a); or (c) if there is inadequate information provided to use item 73055; <i>(See para PP.11 of explanatory notes to this Category)</i> Fee: \$19.60 Benefit: 75% = \$14.70 85% = \$16.70</p>
73055	<p>Cytology of a smear from cervix, not associated with item 73053, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test (a) for the management of previously detected abnormalities including precancerous or cancerous conditions; or (b) for the investigation of women with symptoms, signs or recent history suggestive of cervical neoplasia; <i>(See para PP.11 of explanatory notes to this Category)</i> Fee: \$19.60 Benefit: 75% = \$14.70 85% = \$16.70</p>
73057	<p>Cytology of smears from vagina, not associated with item 73053 or 73055 and not to monitor hormone replacement therapy, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test <i>(See para PP.11 of explanatory notes to this Category)</i> Fee: \$19.60 Benefit: 75% = \$14.70 85% = \$16.70</p>
73059	<p>Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 73061 (Item is subject to rule 13) Fee: \$43.30 Benefit: 75% = \$32.50 85% = \$36.85</p>
73060	<p>Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 or more antibodies (Item is subject to rule 13) Fee: \$57.75 Benefit: 75% = \$43.35 85% = \$49.10</p>
73061	<p>Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 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</p>

PATHOLOGY	PATHOLOGY
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: \$365.20 Benefit: 75% = \$273.90 85% = \$310.45
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; or (b) the patient has a relative with a fragile X (A) mutation 1 or more tests <i>(See para PP.12 of explanatory notes to this Category)</i> 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 <i>(See para PP.12 of explanatory notes to this Category)</i> Fee: \$206.20 Benefit: 75% = \$154.65 85% = \$175.30
73308	Characterisation of the genotype of a patient for Factor V Leiden gene mutation, or detection of the other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism - 1 or more tests Fee: \$37.10 Benefit: 75% = \$27.85 85% = \$31.55
73311	Characterisation of the genotype of a person who is a first degree relative of a person who has proven to have 1 or more abnormal genotypes under item 73308 - 1 or more tests Fee: \$37.10 Benefit: 75% = \$27.85 85% = \$31.55
73314	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: \$235.00 Benefit: 75% = \$176.25 85% = \$199.75
73317	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: \$37.10 Benefit: 75% = \$27.85 85% = \$31.55
‡ 73320	Detection of HLA-B27 by nucleic acid amplification includes a service described in 71147 unless the service in item 73320 is rendered as a pathologist determinable service. (Item is subject to rule 27) Fee: \$41.25 Benefit: 75% = \$30.95 85% = \$35.10

PATHOLOGY	PATHOLOGY
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% = \$7.35 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: \$28.85 Benefit: 75% = \$21.65 85% = \$24.55
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% = \$7.65 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: \$29.15 Benefit: 75% = \$21.90 85% = \$24.80

PATHOLOGY	PATHOLOGY
GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS	
	<i>Para PA.2.1 of the explanatory notes refers to all items in Group P9.</i>
73801	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: \$2.35 Benefit: 75% = \$1.80 85% = \$2.00
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

PATHOLOGY	PATHOLOGY
GROUP P10 - PATIENT EPISODE INITIATION	
73901	<p>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</p> <p>Fee: \$8.25 Benefit: 75% = \$6.20 85% = \$7.05</p>
73903	<p>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</p> <p>Fee: \$14.75 Benefit: 75% = \$11.10 85% = \$12.55</p>
73905	<p>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</p> <p>Fee: \$8.25 Benefit: 75% = \$6.20 85% = \$7.05</p>
73907	<p>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</p> <p>Fee: \$17.40 Benefit: 75% = \$13.05 85% = \$14.80</p>
73909	<p>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</p> <p>Fee: \$17.70 Benefit: 75% = \$13.30 85% = \$15.05</p>
73910	<p>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</p> <p>Fee: \$10.30 Benefit: 75% = \$7.75 85% = \$8.80</p>
73912	<p>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</p> <p>Fee: \$17.70 Benefit: 75% = \$13.30 85% = \$15.05</p>
73913	<p>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</p> <p>Fee: \$9.80 Benefit: 75% = \$7.35 85% = \$8.35</p>
73915	<p>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</p> <p>Fee: \$9.80 Benefit: 75% = \$7.35 85% = \$8.35</p>
GROUP P11 - SPECIMEN REFERRED	
73921	<p>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</p> <p>(Item is subject to rules 14, 15 and 16)</p> <p>Fee: \$10.30 Benefit: 75% = \$7.75 85% = \$8.80</p>

PATHOLOGY		PATHOLOGY	
		GROUP P12 - MANAGEMENT OF BULK-BILLED SERVICES	
		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.13 of explanatory notes to this Category)	
74990	Fee: \$6.20		Benefit: 85% = \$5.30
		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.13 of explanatory notes to this Category)	
74991	Fee: \$9.40		Benefit: 85% = \$8.00

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 – microdocheotomy	6
Breast tissue - all specimens not otherwise specified	4
Bronchus, biopsy	4
Carotid body - neoplasm	5
Cholesteatoma	3
Digits, amputation - not traumatic	4
Digits, amputation - traumatic	2
Ear, middle and inner - not cholesteatoma	4
Endocrine neoplasm - not otherwise specified	5
Extremity, amputation or disarticulation - neoplasm	6
Extremity, amputation - not otherwise specified	4
Eye, conjunctiva - biopsy or pterygium	3
Eye, cornea	4
Eye, enucleation or exenteration - all lesions	6
Eye - not otherwise specified	4
Fallopian tube, biopsy	4
Fallopian tube, ectopic pregnancy	4
Fallopian tube, sterilization	2
Fetus with dissection	6
Foreskin - new born	2
Foreskin - not new born	3
Gallbladder	3
Gallbladder and porta hepatis-radical resection	6
Ganglion cyst, all sites	3
Gum or oral mucosa, biopsy	4

Heart valve	4
Heart - not otherwise specified	5
Hernia sac	2
Hydrocele sac	2
Jaw, upper or lower, including bone, radical resection for neoplasm	6
Joint and periarticular tissue, without bone - all specimens	3
Joint tissue, including bone - all specimens	4
Kidney, biopsy including transplant	5
Kidney, nephrectomy transplant	5
Kidney, partial or total nephrectomy or nephroureterectomy - neoplasm	6
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

CATEGORY 8 – MISCELLANEOUS SERVICES

EXPLANATORY NOTES

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M.6 PROVISION OF PSYCHOLOGICAL THERAPY SERVICES BY CLINICAL PSYCHOLOGISTS (ITEMS 80000 TO 80020)

M.6.1 Overview of the Medicare Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative

Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme initiative commenced on 1 November 2006. It includes the introduction of new MBS items that provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

M.6.2 PSYCHOLOGICAL THERAPY SERVICES ATTRACTING MEDICARE REBATES

Eligible psychological therapy services

There are five MBS items for the provision of psychological therapy services to eligible patients by a clinical psychologist. The clinical psychologists must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

Services provided under the Psychological Therapy items will not attract a Medicare rebate unless:

- the patient is being managed under a GP Mental Health Care Plan (item 2710 or 2712);
- the patient is being managed under a psychiatrist assessment and management plan (item 291 or 293); or
- an eligible psychiatric or paediatric service has been provided and claimed.

Number of services per year

Medicare rebates are available for up to twelve allied mental health services in a calendar year. The twelve services may consist of: psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165 and/or Access to Allied Psychological Services (ATAPS) consultations under the Better Outcomes in Mental Health Care Program. After an initial group of six services, the practitioner managing the patient will conduct a review of the need for further services, before a further six may be provided. In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above that already provided (to a maximum total of 18 services per patient per calendar year). In these cases a new referral should be provided, and exceptional circumstances noted in that referral.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group psychotherapy with 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies – social worker) apply. These group services are separate from the individual services and do not count towards the 12 service calendar year maximum associated with those items.

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies – allied mental health services in excess of twelve (12) in a calendar year (apart from where exceptional circumstances apply) will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

Items 80000 to 80020 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a medical practitioner who is managing the patient under a GP Mental Health Care Plan (item 2710 or 2712); and/or a psychiatrist assessment and management plan (item 291 or 293); or on referral from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for psychological therapy services

Patients seeking Medicare rebates for psychological therapy services will need to have a referral from a GP, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied health services already claimed by the patient during the calendar year.

Clinical psychologists can call Medicare Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

Publicly funded services

Psychological therapy items 80000 to 80020 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. However, 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 items apply for services that are provided by eligible clinical psychologists salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

For further information about Medicare and the MBS, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

M.6.3 REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED MENTAL HEALTH PROFESSIONALS)

Referrals

Patients must be referred for psychological therapy services by a GP managing the patient under a GP Mental Health Care Plan (item 2710 or 2712); and/or a psychiatrist assessment and management plan (item 291 or 293); or on referral from a psychiatrist or a paediatrician. Referring practitioners are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible clinical psychologist signed and dated by the referring practitioner.

The clinical psychologist must be in receipt of the referral at the first allied mental health consultation. A clinical psychologist is required to retain the referral form for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity

The referral remains valid for the stated number of services. If the services are not used during the calendar year in which the patient is referred, the unused services may be used in the next calendar year. However, they will be counted as part of the twelve (12) rebates for psychological therapy services and/or focussed psychological strategies – allied mental health services available to the patient during that calendar year (that is, the patient may only claim up to twelve (12) rebates in total each year).

Subsequent referrals

Where patients wish to access Medicare benefits for eligible psychological therapy or focussed psychological strategies – allied mental health services during their next period of eligibility for rebates (that is, the next calendar year), they should see their GP to obtain a new referral when they have used up their current referral.

M.6.4 ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

All consultations providing psychological therapy services must be rendered by a clinical psychologist with membership of the Australian Psychological Society's College of Clinical Psychology or equivalent, and who is registered with Medicare Australia.

Registering with Medicare Australia

Advice about registering with Medicare Australia to provide psychological therapy services using items 80000-80020 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

M.6.5 ADDITIONAL REQUIREMENTS OF THE PSYCHOLOGICAL THERAPY SERVICES

Service length and type

Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor. The allied health professional must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

In addition to psycho-education, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies – such as interpersonal therapy – may be used if considered clinically relevant.

Reporting back to the referring medical practitioner

On completion of the course of treatment, the clinical psychologist must provide a written report to the referring medical practitioner. The written report provided to the referring medical practitioner should include information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline. A copy of the Medicare Allied Health and Dental Care Supplement can be accessed from this site. The Supplement includes more information about Medicare, including how to make a claim from Medicare.

Further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

M.7 PROVISION OF FOCUSED PSYCHOLOGICAL STRATEGIES SERVICES BY ALLIED HEALTH PROVIDERS (ITEMS 80100 TO 80170)

M.7.1 Overview of the Medicare Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative

Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme initiative commenced on 1 November 2006. It includes the introduction of new MBS items that provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

M.7.2 FOCUSED PSYCHOLOGICAL STRATEGIES – ALLIED MENTAL HEALTH SERVICES ATTRACTING MEDICARE REBATES

Eligible focussed psychological strategies services

There are fifteen MBS items for the provision of focussed psychological strategies (FPS) – allied mental health services to eligible patients by allied health professionals:

- 80100, 80105, 80110, 80115 and 80120 for provision of FPS services by a psychologist;
- 80125, 80130, 80135, 80140 and 80145 for provision of FPS services by an occupational therapist; and
- 80150, 80155, 80160, 80165 and 80170 for provision of FPS services by a social worker.

The allied health professional must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

Services provided under the focussed psychological strategies – allied mental health items will not attract a Medicare rebate unless:

- the patient is being managed under a GP Mental Health Care Plan (item 2710 or 2712);
- the patient is being managed under a psychiatrist assessment and management plan (item 291 or 293); or
- an eligible psychiatric or paediatric service has been provided and claimed.

Number of services per year

Patients will be eligible to claim Medicare rebates for up to twelve allied mental health services in a calendar year. These twelve services may consist of: psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165 and/or Access to Allied Psychological Services (ATAPS) consultations under the Better Outcomes in Mental Health Care Program. After an initial group of six services, the practitioner managing the patient will conduct a review of the need for further services, before a further six may be provided. In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above that already provided (to a maximum total of 18 services per patient per calendar year). In these cases a new referral should be provided, and exceptional circumstances noted in that referral.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group psychotherapy with 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the 12 service calendar year maximum associated with those items.

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies services in excess of twelve (12) in a calendar year (apart from where exceptional circumstances apply) will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

Items 80100 to 80170 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a medical practitioner who is managing the patient under a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for focussed psychological strategies – allied mental health services

Patients seeking Medicare rebates for focussed psychological strategies – allied mental health services will need to have a referral from a GP, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied health services already claimed by the patient during the calendar year.

Clinical psychologists can call Medicare Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

Publicly funded services

FPS items 80100 to 80170 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. However, 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 FPS items apply for services that are provided by eligible allied mental health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

For further information about Medicare and the MBS, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

M.7.3 REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED MENTAL HEALTH PROFESSIONALS)

Referrals

Patients must be referred for FPS services by a GP managing the patient under a GP Mental Health Care Plan (item 2710 or 2712); and/or a psychiatrist assessment and management plan (item 291 or 293); or on referral from a psychiatrist or a paediatrician. Referring practitioners are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied mental health professional signed and dated by the referring practitioner.

The allied mental health professional must be in receipt of the referral at the first allied mental health consultation. An allied mental health professional is required to retain the referral form for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity

The referral remains valid for the stated number of services. If the services are not used during the calendar year in which the patient is referred, the unused services may be used in the next calendar year. However, they will be counted as part of the twelve (12) rebates for psychological therapy services and/or focussed psychological strategies – allied mental health services available to the patient during that calendar year (that is, the patient may only claim up to twelve (12) rebates in total each year).

Subsequent referrals

Where patients wish to access Medicare benefits for eligible psychological therapy services or focussed psychological strategies during their next period of eligibility for rebates (that is, the next calendar year), they should see their GP to obtain a new referral when they have used up their current referral.

M.7.4 ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

Allied health professionals 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 must be:

- A psychologist registered with the Psychologists Registration Board in the State or Territory in which they are practising. (Psychologists whose State/Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use the FPS item); or
- A full or part-time member of OT AUSTRALIA with a minimum of two years of experience in mental health and an undertaking to abide by The Australian Competency Standards for Occupational Therapists in Mental Health; or
- A member of the Australian Association of Social Workers (AASW), including certification by the AASW as meeting the standards for mental health set out in the AASW's 'Standards for Mental Health Social Workers 1999'.

Registering with Medicare Australia

Advice about registering with Medicare Australia to provide focussed psychological strategies – allied mental health services using items 80100-80170 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

M.7.5 ADDITIONAL REQUIREMENTS OF THE FOCUSED PSYCHOLOGICAL STRATEGIES SERVICES

Service length and type

Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor. The allied health professional must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

A range of acceptable strategies has been approved for use by allied health professionals utilising the FPS items. 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** (especially for depression)

There is flexibility to include narrative therapy for Aboriginal and Torres Strait Islander people.

Reporting back to the referring medical practitioner

On completion of the course of treatment, the allied health professional must provide a written report to the referring medical practitioner. The written report provided to the referring medical practitioner should include information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline. A copy of the Medicare Allied Health and Dental Care Supplement can be accessed from this site. The Supplement includes more information about Medicare, including how to make a claim from Medicare.

Further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

M.8 PREGNANCY SUPPORT COUNSELLING SERVICES (ITEMS 81000 TO 81010)

M.8.1 Overview of the Pregnancy Support Counselling Initiative

The Pregnancy Support Counselling initiative commenced on 1 November 2006. It provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to women who are concerned about a current pregnancy, or a pregnancy that occurred in the preceding 12 months, by an eligible medical practitioner (including a general practitioner, but not including a specialist or consultant physician) or allied health professional on referral from a medical practitioner. The term 'GP' is used hereafter as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician).

M.8.2 NON-DIRECTIVE PREGNANCY SUPPORT COUNSELLING SERVICES ATTRACTING MEDICARE REBATES

Eligible pregnancy support counselling services

There are four new MBS items for the provision of non-directive pregnancy support counselling services:

- Item 4001 – services provided by an eligible GP;
- Item 81000 – services provided by an eligible psychologist;
- Item 81005 – services provided by an eligible social worker; and
- Item 81010 – services provided by an eligible mental health nurse.

These notes relate to items 81000-81010. Explanatory notes relating to item 4001 are available at note A.43.

Each individual allied health professional must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

Number of services per year

Medicare benefits are available for up to three (3) eligible non-directive pregnancy support counselling services per patient, per pregnancy, provided using items 81000, 81005, 81010 and 4001 (see Explanatory notes A.43). The Medicare benefit payable for an eligible service provided using item 81000, 81005 or 81010 is \$55.00.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service.

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Non-directive pregnancy support counselling services in excess of three (3) per pregnancy will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

Items 81000-81010 inclusive are available to women who are concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, and where the patient is referred to an eligible allied health professional by a GP.

The items may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

Publicly funded services

Items 81000, 81005 and 81010 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.

However, 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, items 81000, 81005 and 81010 can be claimed for services provided by an eligible psychologist, social worker or mental health nurse salaried by or contracted to the service, where all requirements of the relevant item are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

M.8.3 REFERRAL REQUIREMENTS (GPs TO ALLIED HEALTH PROFESSIONALS)

Referral Form

Patients must be referred for non-directive pregnancy support counselling services by a GP. GPs are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring GP.

Patients may be referred by a GP to more than one eligible allied health professional for eligible non-directive pregnancy support counselling services (for example, where a patient does not wish to continue receiving services from the provider they were referred to in the first instance). However, Medicare benefits are only available for a maximum of three (3) non-directive pregnancy support counselling services to which items 4001, 81000, 81005 and 81010 apply, per patient, per pregnancy.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with Medicare Australia on 132 011. Alternatively, the psychologist, social worker or mental health nurse may check with Medicare Australia.

The relevant allied health professional must be in receipt of the referral at the first non-directive pregnancy support counselling service and must retain the referral for 2 years from the date the service was rendered, for Medicare Australia auditing purposes.

A copy of the referral is **not** required to accompany Medicare claims. However, referral details are required to be included on patients' itemised accounts/receipts or Medicare assignment of benefit forms.

Referral validity

The referral is valid for up to three (3) non-directive pregnancy support counselling services, per patient, per pregnancy.

Subsequent referrals

A new referral is required where the patient seeks to access non-directive pregnancy support counselling in relation to a different pregnancy or where the patient wishes to be referred to a different allied health professional than the one they were referred to in the first instance.

M.8.4 ALLIED HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

Items 81000, 81005 and 81010 can only be claimed for services provided by psychologists, social workers and mental health nurses who are registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, a psychologist, social worker or mental health nurse 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.

Specific eligibility requirements

Specific eligibility requirements for psychologists, social workers and mental health nurses providing services under these items are as follows:

- To be eligible to provide services using MBS Item 81000, a **psychologist** must be registered with the Psychologists Registration Board in the State or Territory in which they are practising (psychologists whose State/Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use item 81000), and have completed appropriate non-directive pregnancy counselling training;
- To be eligible to provide services using MBS Item 81005, a **social worker** must be a 'Member' of the Australian Association of Social Workers (AASW), be certified by AASW as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999', and have completed appropriate non-directive pregnancy counselling training;
- To be eligible to provide services using MBS Item 81010, a **mental health nurse** must be a 'Credentialled Mental Health Nurse' as certified by the Australian and New Zealand College of Mental Health Nurses (ANZCMHN), and have completed appropriate non-directive pregnancy counselling training.

Registering with Medicare Australia

Advice about registering with Medicare Australia to provide non-directive pregnancy support counselling services using items 81000-81010 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

M.8.5 ADDITIONAL REQUIREMENTS OF THE NON-DIRECTIVE PREGNANCY SUPPORT COUNSELLING SERVICE

Service length and type

Non-directive pregnancy support counselling services provided by eligible psychologists, social workers and mental health nurses using items 81000-81010 inclusive must be of at least 30 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

The service involves the psychologist, social worker or mental health nurse undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

Non-directive counselling is a form of counselling which is based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision that is best for them.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline. A copy of the Medicare Allied Health and Dental Care Supplement can be accessed from this site. The Supplement includes more information about Medicare, including how to make a claim from Medicare.

Further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

GROUP M6 - PSYCHOLOGICAL THERAPY SERVICES

† 80000	<p>Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting more than 30 minutes but less than 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) (See para M.6 of explanatory notes to this Category) Fee: \$88.20 Benefit: 85% = \$75.00</p>
† 80005	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the service requirements outlined for item 80000. (See para M.6 of explanatory notes to this Category) Fee: \$110.20 Benefit: 85% = \$93.70</p>
† 80010	<p>Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting at least 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) (See para M.6 of explanatory notes to this Category) Fee: \$129.40 Benefit: 85% = \$110.00</p>
† 80015	<p>Professional attendance at a place other than consulting rooms</p> <p>As per the service requirements outlined for item 80010. (See para M.6 of explanatory notes to this Category) Fee: \$151.40 Benefit: 85% = \$128.70</p>
† 80020	<p>Professional attendance for the purpose of providing psychological therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80120, 80145 and 80170 apply).</p> <p>- GROUP PSYCHOTHERAPY with a group of 6 to 10 patients, EACH PATIENT (See para M.6 of explanatory notes to this Category) Fee: \$32.90 Benefit: 85% = \$28.00</p>

MISCELLANEOUS	MISCELLANEOUS
GROUP M7 - FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
† 80100	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry; or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. <i>(See para M.7 of explanatory notes to this Category)</i></p> <p>Fee: \$62.50 Benefit: 85% = \$53.15</p>
† 80105	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the psychologist service requirements outlined for item 80100. <i>(See para M.7 of explanatory notes to this Category)</i></p> <p>Fee: \$84.95 Benefit: 85% = \$72.25</p>
† 80110	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry; or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. <i>(See para M.7 of explanatory notes to this Category)</i></p> <p>Fee: \$88.20 Benefit: 85% = \$75.00</p>
† 80115	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the psychologist service requirements outlined for item 80110. <i>(See para M.7 of explanatory notes to this Category)</i></p> <p>Fee: \$110.70 Benefit: 85% = \$94.10</p>
† 80120	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry; or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80145 and 80170 apply).</p> <p>GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT <i>(See para M.7 of explanatory notes to this Category)</i></p> <p>Fee: \$22.45 Benefit: 85% = \$19.10</p>
† 80125	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry; or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. <i>(See para M.7 of explanatory notes to this Category)</i></p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>

MISCELLANEOUS	MISCELLANEOUS
† 80130	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the occupational therapist service requirements outlined for item 80125. (See para M.7 of explanatory notes to this Category)</p> <p>Fee: \$77.50 Benefit: 85% = \$65.90</p>
† 80135	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry; or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(See para M.7 of explanatory notes to this Category)</p> <p>Fee: \$77.70 Benefit: 85% = \$66.05</p>
† 80140	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the occupational therapist service requirements outlined for item 80135. (See para M.7 of explanatory notes to this Category)</p> <p>Fee: \$100.15 Benefit: 85% = \$85.15</p>
† 80145	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry; or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80120 and 80170 apply).</p> <p>GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para M.7 of explanatory notes to this Category)</p> <p>Fee: \$19.75 Benefit: 85% = \$16.80</p>
† 80150	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry; or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(See para M.7 of explanatory notes to this Category)</p> <p>Fee: \$55.05 Benefit: 85% = \$46.80</p>
† 80155	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the social worker service requirements outlined for item 80150. (See para M.7 of explanatory notes to this Category)</p> <p>Fee: \$77.50 Benefit: 85% = \$65.90</p>

MISCELLANEOUS

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<p>† 80160</p>	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry; or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. <i>(See para M.7 of explanatory notes to this Category)</i></p> <p>Fee: \$77.70 Benefit: 85% = \$66.05</p>
<p>† 80165</p>	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the social worker service requirements outlined for item 80160. <i>(See para M.7 of explanatory notes to this Category)</i></p> <p>Fee: \$100.15 Benefit: 85% = \$85.15</p>
<p>† 80170</p>	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a consultant physician specialising in the practice of his or her field of psychiatry; or a consultant physician specialising in the practice of his or her field of paediatrics.</p> <p>These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80120 and 80145 apply).</p> <p>GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT <i>(See para M.7 of explanatory notes to this Category)</i></p> <p>Fee: \$19.75 Benefit: 85% = \$16.80</p>

GROUP M8 - PREGNANCY SUPPORT COUNSELLING

† 81000	<p>Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by an eligible psychologist, where the patient is referred to the psychologist by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes.</p> <p>This service may be provided by a psychologist who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a psychologist who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.</p> <p>To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items –81000, 81005, 81010 and 4001 (See para M.8 of explanatory notes to this Category)</p> <p>Fee: \$64.70 Benefit: 85% = \$55.00</p>
† 81005	<p>Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by an eligible social worker, where the patient is referred to the social worker by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes.</p> <p>This service may be provided by a social worker who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a social worker who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.</p> <p>To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items –81000, 81005, 81010 and 4001 (See para M.8 of explanatory notes to this Category)</p> <p>Fee: \$64.70 Benefit: 85% = \$55.00</p>
† 81010	<p>Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by an eligible mental health nurse, where the patient is referred to the mental health nurse by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes.</p> <p>This service may be provided by a mental health nurse who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a mental health nurse who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.</p> <p>To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items - 81000, 81005, 81010 and 4001 (See para M.8 of explanatory notes to this Category)</p> <p>Fee: \$64.70 Benefit: 85% = \$55.00</p>