

**Australian Government
Department of Health and Ageing**

Medicare Benefits Schedule Book

Operating from 1 November 2007

© Commonwealth of Australia 2007

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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>

INTRODUCTION

Schedules of Services

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

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

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

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

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

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

Structure of Schedule of Services

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

Explanatory Notes

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

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

Schedule Interpretations

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

NSW – 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

SOUTH AUSTRALIA

11 Waymouth Street
ADELAIDE SA 5000
Tel (08) 8237 8111

**AUSTRALIAN
CAPITAL
TERRITORY**

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

VICTORIA

595 Collins Street
MELBOURNE VIC 3000
Tel (03) 9665 8888

WESTERN AUSTRALIA

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

**NORTHERN
TERRITORY**

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

QUEENSLAND

Samuel Griffith Place
340 Adelaide Street
BRISBANE QLD 4000
Tel (07) 3360 2555

TASMANIA

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

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 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 2007:

- A 2.2% 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); and
- a 2.2% increase will apply to all other items except Diagnostic Imaging and Pathology item.

Increase in Maximum Gap Payment

The maximum patient gap between the Schedule fee and the benefits payable for out-of-hospital services increases to \$65.20 as at 1 November 2007. The 85% benefit level will apply for all fees up to \$434.65, after which, benefits are calculated at the Schedule fee less \$65.20.

REVIEW OF GENERAL MEDICAL SERVICES

Professional Attendances

Consultant Physician Treatment and Management Plan

- Two new items, 132 and 133, have been introduced for comprehensive consultations with consultant physician where the patient has at least two morbidities.
- Item 132 provides for an initial consultation of at least 45 minutes where the consultant physician provides a consultant physician treatment and management plan to the referring practitioner.
- Item 133 provides for a consultation of at least 20 minutes where the plan provided under item 132 is reviewed.

New Group A28-Geriatric Medicine

- New items 141 and 145 provide for a comprehensive assessment and creation of a geriatrician management plan for a patient over 65, where the attendance is at least 60 minutes duration.
- New items 143 and 147 provide for a comprehensive consultation of at least 30 minutes where the plan created under item 141 or item 145 is reviewed.

Consultant Psychiatry - Telepsychiatry

- Two new items, 359 and 361, have been introduced to allow psychiatrists to provide initial tele-consultations on new patients and review referred assessment and management plans created under item 291.
- Explanatory notes A.17 and A.43 have been amended to reflect the new items 359 and 361.

GP Mental Health Care Items

- Amendments to wording of Explanatory Notes to clarify requirements for referring patients to allied mental health services.

Therapeutic Procedures

Vascular

- **Endovascular repair of abdominal aortic aneurysm**- Following a recommendation from the Medical Services Advisory Committee for permanent funding of this procedure, items 33116 and 33119 have been amended to reflect this intention.
- **Selective Internal Radiation Therapy (SIRT) using SIR-Spheres**- Following a recommendation from the Executive of the Medical Services Advisory Committee, interim funding of items 35404, 35406 and 35408 has been extended until May 2011.

Plastic and Reconstructive Surgery

- Items 45025 and 45026 have been amended to clarify that laser resurfacing treatment involving fractional laser therapy should not be claimed under these items
- Explanatory note T8.103.2 has been amended to reflect that only the conditions which can be treated under item 45585 are those which are listed in the item descriptor and the explanatory notes.
- Explanatory note T8.104.1 has been amended to clarify that item 45588 does not cover the correction of soft tissue abnormalities which are a result of the ageing process.

Orthopaedic

- Explanatory note T8.121 has been amended to exclude items 50124 and 50125 from being claimed with arthroscopy items.

Oral and Maxillofacial Surgery

- The Schedule fees have been amended for Items 30058, 30259, 39327, 47735, 50115, 52120, 52132, 52138, 52319, 52379, 53004, 53054, 53058, 53068, and 53413 to maintain parity between Category 3 and Category 4 items.
- 39 new items (45882 – 45996) have been introduced into Category 3 - Oral Maxillofacial Surgery to maintain parity between Category 3 and Category 4 items.
- A number of minor amendments to item descriptors in Category 4.

CHANGES TO DIAGNOSTIC IMAGING SERVICES

- Amendments have been made to the measurement for crown rump length in obstetric and gynaecological item descriptors to reflect current clinical medical practice and consistency with the Nuchal Translucency Guidelines.
- The regulation preventing the payment of a Medicare rebate for multiple musculoskeletal ultrasound scans performed on a single day has been removed and a new note inserted to clarify the conditions contained in the item descriptor for these items.
- Requesting rights for podiatrists have been extended to include three additional musculoskeletal ultrasound items.
- An indexation increase of 2.2% has been applied to bulk billed items 64990 and 64991.
- A fee increase of 2.03% has been applied to cardiac imaging items 55113, 55114 and 55115 with a 2% fee increase to cardiac imaging items 55116 and 55117.
- The interim items 56549 and 56551 for CT Colonography (known as CTC) have been replaced by two new items 56552 and 56554. The new items include new fees and conditions for service. This amendment was effective from 1 July 2007.

CHANGES TO PATHOLOGY SERVICES**Group P2 – Chemical**

One new item has been added, 66517, for the quantitation of bile acids in blood in pregnancy. Items 66773 and 66776 have been amended.

Group P3 – Microbiology

Item 69384 has been amended.

Group P4 – Immunology

Nine new items have been added.

Items 71180, 71183 and 71186 for the detection of antibodies to cardiolipin or beta-2 glycoprotein I.

Items 71189, 71192 and 71195 for the detection of specific IgG antibodies to respiratory disease allergens.

Item 71198 for the estimation of serum tryptase for the evaluation of unexplained acute hypotension or suspected anaphylactic event, assessment of risk in stinging insect anaphylaxis, exclusion of mastocytosis, monitoring of known mastocytosis.

Item 71200 for the detection and quantitation, if present, of free kappa or lambda light chains in serum for the diagnosis or monitoring of amyloidosis, myeloma or plasma cell dyscrasias.

Item 71203 for the determination of HLAB5701 status by flow cytometry or cytotoxicity assay prior to the initiation of Abacavir therapy including item 73323 if performed.

Items 71079 and 71165 have been amended.

Group P5 Tissue Pathology

One new item has been added, 72838 for the examination of complexity level 7 biopsy material with multiple tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions – 1 or more separately identified specimens.

Group P7 Genetics

One new item has been added, 73323, for the determination of HLAB5701 status by molecular techniques or cytotoxicity assay prior to the initiation of Abacavir therapy including item 71203 if performed.

Outline of Arrangements

Amendments have been made at PC.2, PF.2, PP.7 and PO.5

Rules

Rules 13 (4), 13 (6) and 14 (8b) have been amended.

Part 5 - Complexity levels for histopathology items

Two new level 7 items have been added.

Breast - orientated wide local excision for carcinoma, weighing at least 70g, with margin assessment

Prostate - radical prostatectomy or cystoprostatectomy for carcinoma.

CHANGES TO DENTAL SERVICES

Items for the new dental initiative can be found in the *Medicare Benefits Schedule Dental Services* book, which is available to download from MBS Online – www.health.gov.au/mbsonline.

SUMMARY OF CHANGES

The 1 November 2007 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 since 1 November 2006

132 133 141 143 145 147 359 361 718 719 10997 12323 13251 30062 30680 30682
 30684 30686 30688 30690 30692 30694 37605 37606 43021 43022 43023 45561 45882 45885 45888 45891
 45894 45897 45900 45903 45906 45909 45912 45915 45918 45921 45924 45939 45945 45975 45978 45981
 45984 45987 45990 45993 45996 56552 56554 61505 65079 65082 65109 65110 65157 65158 65166 65180
 65181 66517 66606 66609 66639 66642 66651 66652 66663 66666 66696 66697 66714 66715 66723 66724
 66756 66757 66780 66783 66789 66790 66792 66804 66805 66816 66817 66820 66821 66826 66827 66830
 69316 69317 69319 69325 69328 69331 69379 69383 69400 69401 69419 69451 69482 69483 69489 69492
 69497 69498 69500 71076 71090 71092 71096 71148 71154 71156 71169 71170 71180 71183 71186 71189
 71192 71195 71198 71200 71203 72838 73309 73312 73315 73318 73321 73323 73923 73925 73927 73929
 73931 73933 73935 73937 73939 81100 81105 81110 81115 81120 81125

New Dental Items to commence on 1 November 2007 - Refer to the Medicare Benefits Schedule Dental Services 1 November 2007 Booklet for more information on this initiative.

85011 85012 85013 85022 85025 85031 85037 85039 85047 85051 85071 85111 85113 85114 85115 85117
 85121 85123 85131 85141 85161 85165 85171 85213 85221 85222 85225 85231 85232 85233 85234 85238
 85241 85245 85311 85314 85316 85322 85323 85324 85326 85331 85337 85338 85341 85377 85378 85381
 85384 85386 85387 85391 85392 85411 85412 85414 85415 85416 85417 85418 85419 85431 85432 85433
 85434 85436 85437 85438 85445 85451 85452 85453 85455 85457 85458 85511 85512 85513 85514 85515
 85521 85522 85523 85524 85525 85531 85532 85533 85534 85535 85541 85542 85543 85544 85545 85551
 85552 85553 85554 85555 85572 85574 85575 85576 85577 85578 85595 85596 85597 85613 85615 85618
 85625 85627 85629 85631 85632 85642 85643 85644 85645 85649 85651 85652 85653 85655 85656 85658
 85659 85661 85669 85671 85672 85673 85711 85712 85716 85719 85721 85722 85727 85728 85731 85732
 85733 85735 85736 85737 85738 85739 85741 85743 85744 85745 85746 85751 85752 85753 85761 85762
 85763 85764 85765 85767 85768 85769 85771 85772 85773 85776 85777 85811 85821 85823 85829 85831
 85911 85926 85927 85949 85963 85964 85965 85966 85968 85971 85972 85981 85986 86012 86013 86014
 86015 86022 86025 86031 86035 86036 86037 86038 86039 86047 86051 86071 86082 86111 86113 86114
 86115 86117 86121 86123 86131 86141 86161 86165 86171 86213 86221 86222 86225 86231 86232 86233
 86234 86235 86236 86237 86238 86241 86245 86311 86314 86316 86322 86323 86324 86326 86331 86332
 86337 86338 86341 86343 86344 86345 86371 86373 86375 86376 86377 86378 86379 86381 86382 86384
 86385 86386 86387 86388 86389 86391 86392 86393 86394 86395 86411 86412 86414 86415 86416 86417
 86418 86419 86431 86432 86433 86434 86436 86437 86438 86445 86451 86452 86453 86455 86457 86458
 86511 86512 86513 86514 86515 86521 86522 86523 86524 86525 86531 86532 86533 86534 86535 86541
 86542 86543 86544 86545 86551 86552 86553 86554 86555 86572 86574 86575 86576 86577 86578 86595
 86596 86597 86613 86615 86618 86625 86627 86629 86631 86632 86642 86643 86644 86645 86649 86651
 86652 86653 86655 86656 86658 86659 86661 86663 86664 86666 86669 86671 86672 86673 86679 86684
 86688 86691 86711 86712 86716 86719 86721 86722 86727 86728 86731 86732 86733 86735 86736 86737
 86738 86739 86741 86743 86744 86745 86746 86751 86752 86753 86761 86762 86763 86764 86765 86767
 86768 86769 86771 86772 86773 86776 86777 86811 86821 86823 86829 86831 86862 86911 86926 86927
 86949 86963 86964 86965 86966 86968 86971 86972 86981 86986 87011 87014 87071 87111 87112 87116
 87119 87121 87122 87127 87128 87131 87132 87133 87136 87137 87138 87139 87141 87143 87144 87145
 87146 87151 87152 87153 87161 87162 87163 87164 87165 87167 87168 87169 87171 87176 87177

Deleted Items since 1 November 2006

2574 2575 2577 2578 2704 2705 2707 2708 42875 42878 42881 42884 42887 42990 42991 42993
 42996 42999 43000 43002 43005 43008 43011 43014 43017 56549 56551 66713 66737 66809 66818 69402

Amended Description since 1 November 2006

1 2 97 98 293 296 297 299 300 302 304 306 308 310 312 314
 316 318 319 353 364 448 449 601 602 697 698 2710 2721 10950 10951 10952
 10953 10954 10956 10958 10960 10962 10964 10966 10968 10970 10975 10976 10977 10988 10989 10990
 10991 10992 10993 10994 10995 10996 10998 10999 11820 14245 15338 31300 33116 33119 37220 37227
 38200 38203 38206 45025 45026 45564 45565 51700 51703 51900 51902 51904 51906 52012 52015 52018
 52024 52027 52030 52033 52036 52039 52042 52045 52048 52051 52054 52055 52056 52057 52058 52059
 52060 52061 52062 52063 52064 52094 52095 52097 52098 52102 52106 52130 52131 52135 52144 52180
 52182 52184 52186 52300 52303 52306 52309 52312 52315 52321 52424 52430 52800 52803 52806 52809
 52812 52815 52818 52821 52828 52830 52832 53206 53706 55700 55703 55704 55705 55707 55708 65150
 65153 65156 65175 65178 66539 66551 66554 66626 66650 66653 66655 66659 66695 66711 66712 66750
 66751 66752 66773 66776 66785 66788 69384 69399 69445 71075 71077 71079 71089 71091 71093 71147
 71153 71155 71157 71159 71165 73523 80000 80010 80020 80100 80110 80120 80125 80135 80145 80150
 80160 80170 85761

Fee Amended since 1 November 2006

4 13 19 20 24 25 33 35 37 38 40 43 47 48 50 51 92
 93 95 96 195 299 353 355 356 357 358 367 369 414 415 416 417
 716 729 731 2503 2506 2509 2518 2522 2526 2547 2553 2559 2723 2727 5003 5007
 5010 5023 5026 5028 5043 5046 5049 5063 5064 5067 5260 5263 5265 5267 10950 10951
 10952 10953 10954 10956 10958 10960 10962 10964 10966 10968 10970 10975 10976 10977 12306 12309
 12312 12315 12318 12321 12323 13015 15003 15009 15103 15109 15115 15214 15230 15233 15236 15239
 15242 15260 15263 15266 15269 15272 18219 18227 30058 30259 36658 36660 36662 39327 43021 43022
 43023 47735 50115 52120 52132 52138 52319 52379 53004 53054 53058 53068 53413 55113 55114 55115
 55116 55117 61462 65099 65102 65105 65108 65176 65178 65179 66653 66698 66701 66707 66806 69387
 69390 69396 69399 71091 71093 80000 80005 80010 80015 80020 80100 80105 80110 80115 80120 80125
 80130 80135 80140 80145 80150 80155 80160 80165 80170 81000 81005 81010 81100 81105 81110 81115
 81120 81125

Item Number Change since 1 November 2006

Old	New	Old	New	Old	New	Old	New
65132	65175	65133	65176	65134	65177	65135	65178
65136	65179	66669	66819	66670	66822	66672	66825
66673	66828	69486	69418	69442	69488	69443	69491
69364	69494	69365	69495	69367	69496	69444	69499
71109	71165	71113	71166	71115	71167	71117	71168
73901	73922	73903	73924	73905	73926	73907	73928
73909	73930	73910	73932	73912	73934	73913	73936
73915	73938	73921	73940				

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 2007 and continues beyond that date, the general rule is that the 1 November 2006 level of fees and benefits would apply.

MEDICARE BENEFIT ARRANGEMENTS

1.1 Outline of the Medicare Scheme

1.1.1 The Medicare Program ('Medicare') provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. **Medicare Australia** administers Medicare and the payment of Medicare benefits.

1.1.2 The major elements of Medicare are contained in the *Health Insurance Act 1973*, as amended, and include the following:

- Free treatment for public patients in public hospitals.
- The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are:
 - o 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
 - o 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or registered Aboriginal Health Worker;
 - o 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
 - o 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

1.1.3 Medicare benefits are only claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the profession in question as necessary for the appropriate treatment of the patient. When a service is not clinically relevant (see General Explanatory Note 13 for more information on services not attracting a Medicare Benefit), the fee and payment arrangements are a private matter between the practitioner and the patient.

1.1.4 Services listed in the MBS must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws. For example, medical practitioners must ensure that the medicines and medical devices they use have been supplied to them in strict accordance with the provisions of the *Therapeutic Goods Act 1989*.

1.1.5 Where a Medicare benefit has been inappropriately paid, Medicare Australia may request its return from the practitioner concerned.

1.1.6 'Out-of-pocket' medical expenses are the difference between the fee the doctor charges and the Medicare benefit paid to the patient. Patients are protected against high out-of-pocket expenses for non-admitted services listed in the MBS, by the 'original' Medicare safety net and the 'extended' Medicare safety net:

- Under the extended safety net, Medicare rebates 80% of out-of-pocket expenses for non-admitted services, once certain thresholds are reached. In 2007, concession cardholders and families receiving Family Tax Benefit (Part A) are eligible for the extended Medicare safety net when their cumulative out-of-pocket expenses reach \$519.50; all other individuals and families are eligible when their cumulative out-of-pocket expenses reach \$1,039.00. The extended Medicare safety net operates with the original safety net.
- Under the original safety net, the Medicare benefit for non-admitted services increases to 100% of the Schedule fee, once cumulative out-of-pocket expenses reach \$358.90. Thereafter, any remaining out-of-pocket expenses count towards meeting the extended Medicare safety net threshold.

1.1.7 While individuals are automatically registered with Medicare Australia for the safety nets, families must register themselves to be eligible. Registration forms can be obtained from Medicare Australia offices or completed online at www.medicareaustralia.gov.au

1.2 Key information on Medicare benefits and billing practices

1.2.1 The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services.

- A professional service is a **clinically relevant service** which is listed in the MBS.
- A medical service is **clinically relevant** if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

1.2.2 Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account.

NOTE: Refer to General Explanatory Note 7 for a more detailed explanation on billing procedures.

1.3 Billing practices contrary to the Act

1.3.1 *A non-clinically relevant service must not be included in the charge for a Medicare item.* The non-clinically relevant service must be separately listed on the account and not billed to Medicare.

1.3.2 *Goods supplied for the patient's home use (such as wheelchairs, oxygen tanks, continence pads) must not be included in the consultation charge.* Medicare benefits are limited to services which the medical practitioner provides at the time of the consultation – any other services must be separately listed on the account and must not be billed to Medicare.

1.3.3 *Charging part of all of an episode of hospital treatment or a hospital substitute treatment to a non-admitted consultation is prohibited.* This would constitute a false or misleading statement on behalf of the medical practitioner and no Medicare benefits would be payable.

1.3.4 *An account may not be re-issued to include charges and out-of-pocket expenses not included in the original account.* The account can only be reissued to correct a genuine error.

NOTE: Refer to General Explanatory Note 7 for a more detailed explanation on billing procedures.

1.4 Potential consequence of improperly issuing an account

1.4.1 There are the following potential consequences for improperly issuing an account:

- No Medicare benefits will be paid for the service;
- The medical practitioner who issued the account, or authorised its issue, may face charges under section 128A and 128B of the *Health Insurance Act 1973*.
- Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

1.4.2 Providers should be aware that Medicare Australia is legally obliged to investigate doctors suspected of making false or misleading statements, and may refer them for prosecution if the evidence indicates fraudulent charging to Medicare.

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

2. PROVIDER ELIGIBILITY FOR MEDICARE

2.1 Practitioner access to Medicare benefits

2.1.1 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 (that is the service is not listed in the MBS).

2.1.2 To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:

- be a recognised specialist, consultant physician or general practitioner; or
- be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or
- be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and 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).

2.1.3 Any practitioner who does not satisfy the requirements outlined in General Explanatory Note 2.1.2 may still practice medicine but their services will not be eligible for Medicare benefits.

2.1.4 **Non-medical practitioners:** To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977, and MBS items 80000-88000, allied health professionals, dentists, and dental specialists must be:

- registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and
- registered with Medicare Australia to provide these services.

2.2 Provider Numbers

2.2.1 Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply *in writing* to Medicare Australia for a Medicare provider number for the locations where these services/referrals/requests will be provided. Form may be downloaded from www.medicareaustralia.gov.au

2.2.2 For Medicare purposes, an account/receipt issued by a practitioner must include the practitioner's name and *either* the provider number for the location where the service was provided *or* the address where the services were provided.

2.2.3 Medicare provider number information is released in accord with the secrecy provisions of the *Health Insurance Act 1973* (section 130) to authorized external organizations including private health insurers, the Department of Veterans' Affairs and the Department of Health and Ageing.

2.2.4 When a practitioner ceases to practice at a given location they must inform Medicare promptly. Failure to do so can lead to the misdirection of Medicare cheques and Medicare information.

2.2.5 Practitioners at practices participating in the Practice Incentives Program (PIP) should use a provider number linked to that practice. Under PIP, only services rendered by a practitioner whose provider number is linked to the PIP will be considered for PIP payments.

2.3 Locum tenens

2.3.1 Where a locum tenens will be in a practice for more than two weeks *or* is a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact Medicare Australia (provider liaison – 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

2.3.2 A locum must use the provider number allocated to the location if:

- they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or
- they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or
- they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (that is, they have access to Medicare benefits at specific practice locations); or
- they will be at a practice which is participating in the Practice Incentives Program; or
- they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.

2.4 Overseas trained doctors

2.4.1 **Ten year moratorium:** Section 19AB of the *Health Insurance Act 1973* states that services provided by overseas trained doctors (including New Zealand trained doctors) and former overseas medical students trained in Australia, will not attract Medicare benefits for 10 years from *either* their date of registration as a medical practitioner for the purposes of the *Health Insurance Act 1973* *or* their date of permanent residency (the reference date from will vary from care to case).

Exclusions: practitioners who **before 1 January 1997** had:

- registered with a State or Territory medical board *and* retained a continuing right to remain in Australia; or
- lodged a valid application with the Australian Medical Council (AMC) to undertake examinations whose successful completion would normally entitle the candidate to become a medical practitioner.

2.4.2 The Minister of Health and Ageing may grant an overseas trained doctor (OTD) or occupational trainee (OT) an exemption to the requirements of the ten year moratorium, with or without conditions. When applying for a Medicare provider number, the OTD or OT must:

- (a). demonstrate that they need a provider number and that their employer supports their request; and
- (b). provide the following documentation:
 - Australian medical registration papers; and
 - a copy of their personal details in their passport and all Australian visas and entry stamps; and
 - a letter from the employer stating why the person requires a Medicare provider number and/or prescriber number is required; and
 - a copy of the employment contract.

2.5 Addresses of Medicare Australia

Medicare Australia,
GPO Box 9822,
in the Capital City in each State

Phone: 132-150 for all States and Territories (at 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 TASMANIA

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

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.
- 3.1.2 Applicants for permanent residence may also be eligible persons, depending on circumstances.
- 3.1.3 Eligible persons must enrol with Medicare before they can receive Medicare benefits.
- 3.1.4 Medicare does *not* cover medical, hospital or evacuation expenses incurred outside of Australia. Australians are therefore advised to take out private travel (medical) insurance when traveling abroad.

3.2 Medicare cards

- 3.2.1 The green Medicare card is for people permanently in Australia. Cards may be issued for individuals or families.
- 3.2.2 The blue Medicare card bearing the words "INTERIM CARD" is for people who have applied for permanent residence.
- 3.2.3 Visitors from countries with which Australia has a Reciprocal Health Care Agreement receive a card bearing the words "RECIPROCAL HEALTH CARE" (see section 3.4 below).

3.3 Visitors to Australia and temporary residents

- 3.3.1 Visitors and temporary residents in Australia are not eligible for Medicare and should therefore have adequate private health insurance. **Exception:** visitors from countries with which Australia has a Reciprocal Health Care Agreement (see section 3.4 below)
- 3.3.2 Eligible visitors must enrol with Medicare to receive benefits. The period of eligibility is indicated by the expiry date on the Medicare card.

3.4 Reciprocal Health Care Agreements

- 3.4.1 Australia has Reciprocal Health Care Agreements with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Norway, Italy and Malta.
- 3.4.2 Visitors from these countries are entitled to public hospital care (as public patients), Medicare benefits and drugs under the Pharmaceutical Benefits Scheme (PBS) *if their condition or injury requires treatment before their departure from Australia*. **Partial exception:** Visitors from Ireland and New Zealand are only entitled to public hospital care and PBS drugs, and must present their passports before treatment as they are not issued with Medicare cards.
- 3.4.3 Visitors are eligible for the duration of their stay. **Exception:** Visitors from Italy and Malta are covered for a period of six months only.
- 3.4.4 The Agreements do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving health treatment are not covered under the Agreements.

4. GENERAL PRACTICE

4.1 General Practice

- 4.1.1 Some MBS items may only be used by general practitioners. For MBS purposes a general practitioner is a medical practitioner who is:
 - (a) vocationally registered under section 3F of the *Health Insurance Act 1973* (see General Explanatory Note 4.3 below); or
 - (b) a Fellow of the Royal Australian College of General Practitioners (FRACGP) who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or
 - (c) a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or
 - (d) is undertaking an approved general practice placement in a training program for *either* the award of the FRACGP *or* a training program recognised by the RACGP being of an equivalent standard; or
 - (e) is undertaking an approved general practice placement in a training program for *either* the award of FACRRM *or* a training program recognised by ACRRM as being of an equivalent standard.
- 4.1.2 A medical practitioner seeking recognition as a FRACGP should apply to Medicare Australia, having completed an application from available from Medicare Australia's website. A general practice trainee should apply to General Practice Education and Training Limited (GPET) for a general practitioner trainee placement. GPET will advise Medicare Australia when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on Medicare Australia's website.

4.2 Vocational recognition of general practitioners

4.2.1 The only qualifications leading to vocational recognition are FRACGP and FACRRM. The criteria for recognition as a GP are:

- (a) certification by the RACGP that the practitioner:
 - is a Fellow of the RACGP; and
 - practice is, or will be within 28, predominantly in general practice; and
 - has met minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.
- (b) certification by the General Practice Recognition Eligibility Committee (GPREC) that the practitioner:
 - is a Fellow of the RACGP; and
 - practice is, or will be within 28, predominantly in general practice; and
 - has met minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.
- (c) certification by ACRRM that the practitioner:
 - is a Fellow of ACRRM; and
 - has met minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

4.2.2 In assessing whether a practitioner's medical practice is predominantly in general practice, the practitioner must have at least 50% of clinical time and services claimed against Medicare. Regard will also be given as 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.

4.2.3 Further information on eligibility for recognition should be directed to:

Program Relations Officer, RACGP

Tel: (03) 86990494 Email at: qacpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:

Tel: (02) 6124 6753 Email at co.medicare.eligibility@medicareaustralia.gov.au

Executive Assistant, ACRRM:

Tel: (07) 3105 8200 Email at acrrm@acrrm.org.au

How to apply for vocational recognition

4.2.4 Medical practitioners seeking vocational recognition should apply to Medicare Australia using the approved Application Form available on the Medicare Australia website: www.medicareaustralia.com.au. Applicants should forward their applications, as appropriate, to:

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

Chief Executive Officer
Australian College of Rural and Remote Medicine
GPO Box 2507
BRISBANE Queensland 4001

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

4.2.5 The relevant body will forward the application together with its certification of eligibility to the Medicare Australia CEO for processing.

- 4.2.6 Continued vocational recognition is dependent upon:
- (a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and
 - (b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.
- 4.2.7 Further information on continuing medical education and quality assurance requirements should be directed to the RACGP or the ACRRM depending on the college under which the practitioner is pursuing, or is intending to pursue, continuing medical education.
- 4.2.8 Medical practitioners refused certification by RACGP, the ACRRM or GPREC may appeal to the General Practice Recognition Appeal Committee (GPRAC) in writing to GPRAC, Medicare Australia, PO Box 1001, Tuggeranong, ACT, 2901.

Removal of vocational recognition status

- 4.2.9 A medical practitioner may at any time request Medicare Australia to remove their name from the Vocational Register of General Practitioners.
- 4.2.10 Vocational recognition status can also be revoked if the RACGP, the ACRRM or GPREC certifies to Medicare Australia that it is no longer satisfied that the practitioner should remain vocationally recognised. Appeals of the decision to revoke vocational recognition may be made in writing to GPRAC, at the above address.
- 4.2.11 A practitioner whose name has been removed from the register, or whose determination has been revoked for any reason must make a formal application to re-registered, or for a new determination.

5. RECOGNITION AS A SPECIALIST OR CONSULTANT PHYSICIAN

5.1 Recognition Method

5.1.1 A medical practitioner 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;

and has formally applied and paid the prescribed fee, may be recognised by the Minister as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*.

5.1.2 A medical practitioner who is training for a fellowship of a specified specialist College and is undertaking training placements in a private hospital or in general practice, may provide services which attract Medicare rebates. Specialist trainees should consult the information available at www.medicareaustralia.gov.au/providers/forms/medicare/specialists.shtml

5.1.3 Medical practitioners who have not been recommended for recognition as a specialist or consultant physician by the Specialist Recognition Advisory Committee may appeal to the Specialist Recognition Advisory Committee.

5.1.4 Once recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*, 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 the patient has been referred in accordance with General Explanatory Note 6.

5.1.5 Enquiries relating to this section should be made to Medicare Australia on 132-150 or in writing to:

Provider Liaison Section,
Medicare Australia,

PO Box 9822 in your State capital city. ACT and NT enquiries should be directed to NSW.

5.2 Emergency Medicine

5.2.1 A practitioner will be acting as an emergency medicine specialist when treating a patient within 30 minutes of the patient's 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:

- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);

(b) sub-paragraphs (ii) and (iii) do not apply to:

- a referral generated during an episode of hospital treatment, in respect of a privately insured service provided or arranged by 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 is not required in the case of pre-anaesthesia consultation items 17610-17625. However, for benefits to be payable at the specialist rate for consultations, other than pre-anaesthesia consultations, by specialist anaesthetists (items 17640 -17655) a referral is required. For further information on these items please refer to point T6.

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 during an episode of hospital treatment in respect of a privately insured service provided or arranged by 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 unreferral 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) for professional services rendered to a patient as part of a privately insured episode of hospital treatment; an asterisk '*' directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the word 'patient' ;
- (vii) for professional services rendered as part of a privately insured episode of hospital-substitute treatment and the patient who receives the treatment chooses to receive a benefit from a private health insurer, the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the words 'hospital-substitute treatment';
- (viii) 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);
- (ix) 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;
- (x) 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;
- (xi) 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
- (xii) 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.

7.1.4 The *Private Health Insurance Act 2007* provides for the payment of private health insurance benefits for hospital treatment and general treatment. Hospital treatment is treatment that is intended to manage a disease, injury or condition that is provided to an insured person by a hospital or with the direct involvement of a hospital. General treatment is treatment that is intended to manage or prevent a disease, injury or condition and is not hospital treatment. Hospital-substitute treatment is a direct substitute for an episode of hospital treatment. Health insurers can cover specific professional services as hospital-substitute treatment in accordance with the *Private Health Insurance (Health Insurance Business) Rules 2007*.

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.

7.3.5 Claims for professional services rendered as part of an episode of hospital-substitute treatment should be submitted to the health insurer in the first instance for the payment of private health insurance benefits. The insurer will forward the claim to Medicare Australia for the payment of Medicare benefits

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.

7.4.5 Claims for professional services rendered as part of an episode of hospital-substitute treatment should be submitted to the health insurer in the first instance for the payment of private health insurance benefits. The insurer will forward the claim to Medicare Australia for the payment of Medicare benefits.

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 enrollees have entitlement limited to the date shown on the card and some enrollees, 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 HEALTH PRACTITIONERS (MEDICAL PRACTITIONERS, DENTISTS, OPTOMETRISTS, CHIROPRACTORS, PHYSIOTHERAPISTS, PODIATRISTS, OSTEOPATHS), INDIVIDUAL CLAIMS AND SCHEDULE SERVICES

8.1 Professional Services Review (PSR) Scheme

8.1.1 The PSR reviews and investigates service provision by health practitioners to determine if they have engaged in inappropriate practice when rendering or initiating Medicare services, or when prescribing or dispensing under the PBS.

8.1.2 Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practising when they rendered or initiated the services under review. It is also an offence under Section 82 for a person or 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 Medicare Australia detects an anomaly, it may request the Director of PSR to review the practitioner's service provision. On receiving the request, the Director must decide whether to conduct a review and in which manner the review will be conducted. The Director is authorized to require that documents and information be provided.

8.1.4 Following a review, the Director must:

- decide to take no further action; or
- enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or
- refer the matter to a PSR Committee.

8.1.5 A PSR Committee normally comprises three medically qualified members, two of whom must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide wider range of clinical expertise.

8.1.6 The Committee is authorized to:

- investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;
- hold hearings and require the person under review to attend and give evidence;
- require the production of documents (including clinical notes).

8.1.7 The methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation:

(a) **Patterns of Services** - The *Health Insurance (Professional Services Review) Regulations 1999* specify that when a general practitioner or other medical practitioner reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately.

(i) 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.

(ii) If the practitioner can satisfy the PSR Committee that their pattern of service was as a result of exceptional circumstances, the quantum of inappropriate practice is reduced accordingly. Exceptional circumstances include, but are not limited to, those set out in the *Regulations*. These include:

- an unusual occurrence;
- the absence of other medical services for the practitioner's patients (having regard to the practice location);
- and the characteristics of the patients.

(b) **Sampling** - A PSR Committee may use statistically valid methods to sample the clinical or practice records.

(c) **Generic findings** - If a PSR Committee cannot use patterns of service or sampling (for example, there are insufficient medical records), it can make a 'generic' finding of inappropriate practice.

8.1.8 Additional Information

- A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond
- In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records.
- The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

8.1.9 If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

- a reprimand;
- counselling;
- repayment of Medicare benefits; and/or
- complete or partial disqualification from Medicare benefit arrangements for up to three years.

8.1.10 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 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 applies).

8.3 Referral of professional issues to regulatory and other bodies

8.3.1 The *Health Insurance Act 1973* provides for the following referral, to an appropriate regulatory body:

- a significant threat to a person's life or health, when caused or is being caused or is likely to be caused by the conduct of the practitioner under review;
- a statement of concerns of non-compliance by a practitioner with 'professional standards'.

MBS Services

8.4 Medicare Benefits Consultative Committee (MBCC)

8.4.1 The MBCC is an advisory committee established by agreement between the Minister for Health and Ageing and the Australian Medical Association. The Committee comprises representatives from the Department, Medicare Australia, the Australian Medical Association and relevant craft groups.

8.4.2 The Committee's major function is to review particular services or groups of services in the MBS, including consideration of appropriate fee levels.

8.5 Medical Services Advisory Committee (MSAC)

8.5.1 The MSAC advises 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 MBS, should be supported.

8.5.2 MSAC membership comprises those representing pathology, surgery, internal medicine and general practice, clinical epidemiology and clinical trials, health economics, consumers, and health administration and planning.

8.5.3 For more information on the MSAC refer to their website - www.msac.gov.au - or 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 PSTC comprises six representatives from the interested professions and six from the Australian Government. Its 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 General Explanatory Note 8.5) including the level of fees.

8.7 Review of Claims Requiring Prior Approval for Payment of Benefits

8.7.1 There are MBS items which make the payment of Medicare benefits dependent on a 'demonstrated' clinical need. 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 these services should be lodged with Medicare Australia 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 the payment of benefits.

8.7.3 Practitioners may also apply to Medicare Australia for prospective approval for 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 (oral or written) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a

court 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 \$1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the obligatory details having been entered on the form before the person signs, or who fails to cause a patient to be given a copy of the completed form.

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 MBS 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 2007.

10.1.3 The Schedule fee and Medicare benefit levels for the medical services contained in the MBS 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 Medicare benefit payable exceed the fee actually charged.

There are presently three levels of Medicare benefit payable:

- (i) **75% of the Schedule fee:**
 - for professional services rendered to a privately insured patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' directly after an item number where used; or a description of the professional service, preceded by the word 'patient';
 - for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.
- (ii) **100% of the Schedule fee** 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.
- (iii) **85% of the Schedule fee**, or the Schedule fee less \$65.20 (indexed annually), whichever is the greater, for all other professional services.

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 private health insurers can cover the "patient gap" (that is, 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 insurers for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the doctor has an arrangement with their health insurer.

10.1.9 Where it can be established that payments of \$358.90 (effective from 1 January 2007 and indexed annually from 1 January each year) have been made by a family or an individual during a calendar year regarding the difference between the Medicare benefit and the Schedule fee for out-of-hospital services, benefits will thereafter be paid for the rest of that year up to 100% of the Schedule fee.

11. SERVICES NOT LISTED IN THE MBS

11.1 Services not listed in MBS

11.1.1 Benefits are not generally payable for services not listed in the MBS. 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. For example, intramuscular injections, aspiration needle biopsy, treatment of sebhorreic keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe). Enquiries about services not listed or on matters of interpretation should be directed to Medicare Australia whose postal addresses are listed in General Explanatory Note 2. The following telephone numbers are reserved for MBS enquiries:

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 1973* 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 provision may be used to facilitate payment of benefits for new developed procedures or techniques where close monitoring is desirable. Services which have received section 3C approval are located in their relevant Groups in the MBS with 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. The latter include services where a part 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 1975* 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), unless a group session is involved (i.e. Items 170-172). The requirement of "personal performance" is met whether or not assistance is provided, 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, 14221 and 14245);
- (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), except where the practitioner is exercising their right of private practice, or is performing a medical service outside the hospital. For example, benefits are not paid 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 list at General Explanatory Note 12.1.2 and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-

- (i) the medical practitioner in whose name the service is being claimed;
- (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 So that a service rendered by an employee or under the supervision of a medical practitioner may 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 must be satisfied with the employment and supervision arrangements. While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, 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 medical or paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

12.3 Mass Immunisation

12.3.1 Medicare benefits are payable for a professional attendance that includes an immunisation, provided that the actual administration of the vaccine is not specifically funded through any other Commonwealth or State Government program, nor through an international or private organisation

13. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

13.1 Services not attracting benefits

- telephone consultations;
- issue of repeat prescriptions when the patient does not attend the surgery in person;
- group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);
- non-therapeutic cosmetic surgery;
- euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.

13.2 Medicare benefits are not payable where the medical expenses for the service

- are paid/payable to a public hospital;
- are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);
- are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;
- are incurred in mass immunisation (see General Explanatory Note 12.3 for further explanation).

13.3 Unless the Minister otherwise directs, Medicare benefits are not payable where:

- the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;
- the medical expenses are incurred by the employer of the person to whom the service is rendered;
- the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or
- the services is a health screening service.

13.4 Current regulations preclude the payment of Medicare benefits for professional services rendered in relation to or in association with:

- (a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;
- (b) the injection of human chorionic gonadotrophin in the management of obesity;
- (c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
- (d) the removal of tattoos;
- (e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or 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;
- (f) the removal from a cadaver of kidneys for transplantation;
- (g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

13.5 Non Medicare Services

13.5.1 An item in the range 1 to 10943 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, any of the services specified below

- (a) Endoluminal gastropliation, for the treatment of gastro-oesophageal reflux disease;
- (b) Endovenous laser treatment, for varicose veins;
- (c) Gamma knife surgery;
- (d) Intradiscal electro thermal arthroplasty;
- (e) Intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
- (f) Intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
- (g) Low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
- (h) Lung volume reduction surgery, for advanced emphysema;
- (i) Photodynamic therapy, for skin and mucosal cancer;
- (j) Placement of artificial bowel sphincters, in the management of faecal incontinence;
- (k) Sacral nerve stimulation, for urinary incontinence;
- (l) Selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
- (m) Specific mass measurement of bone alkaline phosphatase;
- (n) Transmyocardial laser revascularisation;
- (o) Vertebral axial decompression therapy, for chronic back pain.

13.6 Health Screening Services

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

13.6.2 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 program, 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;
- for the purposes of legal proceedings;
- compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

13.6.3 The Minister has directed that Medicare benefits be paid for the following categories of health screening:

- a medical examination or 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 their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a Papanicolaou test in a woman (see General Explanatory note 13.6.4 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check up should not necessarily be accompanied by an extensive battery of diagnostic investigations;
- a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;
- medical examinations to obtain a certificate of hearing disability required for a tax exemption for a television decoding device;
- a medical or optometrical examination provided to a person who is an unemployed person (as defined by the *Social Security Act 1991*), at the request of a prospective employer;
- a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or

collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;

- a medical examination being a condition of child adoption or fostering;
- a medical examination being a requisite for Social Security benefits or allowances.

13.6.4 The National Policy on screening for the Prevention of Cervical Cancer (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 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 or two years after first sexual intercourse, whichever is later;
- 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.

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 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 – Professional Attendances and A.36 in the explanatory notes for Category 1 – Professional Attendances.

13.7 Services rendered to a doctor's dependants, practice partner, or practice partner's dependants

13.7.1 Generally, Medicare benefits are not paid for professional services rendered by a medical practitioner to dependants or partners or a partner's dependants.

14. INTERPRETATION OF THE MBS

14.1 Principles of interpretation

14.1.1 Each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.

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. For example, where a radiographic examination is started by one medical practitioner and finalised by another.

14.2 Services attracting benefits on an attendance basis

14.2.1 Some services are not listed in the MBS because they are regarded as forming part of a consultation or they 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, during a single attendance, a consultation (under Category 1 of the MBS) and another medical service (under any other Category of the Schedule) occur, benefits are payable subject to certain exceptions, for both the consultation and the other service. Benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item is qualified by words such as "each attendance", "attendance at which", "including associated attendances/consultations", and all items in Group T6 and T9. 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 Where the level of benefit for an attendance depends upon the consultation time (for example, in psychiatry), the time spent in carrying out a procedure which is covered by another item in the MBS, may not be included in the consultation time.

14.3.3 A consultation fee may only be charged if a consultation occurs; that is, it is not expected that consultation fee will be charged on every occasion a procedure is performed.

14.4 Aggregate items

14.4.1 The MBS includes a number of items which apply only in conjunction with another specified service listed in the MBS. 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.

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.

14.4 Residential aged care facility

14.5.1 A residential aged care facility is defined in the *Aged Care Act 1997*; the definition includes facilities formerly known as nursing homes and hostels.

15. PRACTITIONERS SHOULD MAINTAIN ADEQUATE AND CONTEMPORANEOUS RECORDS

15.1 Requirements

15.1.1 All practitioners who provide, or initiate, a service for 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 Since 1 November 1999 PSR Committees determining issues of inappropriate practice have been obliged to consider if the practitioner kept adequate and contemporaneous records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

15.1.3 The standards which determine if a record is adequate and contemporaneous are prescribed in the 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.

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.

A.3.2 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) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Quality Assurance and Continuing Medical Education program; or
- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program.
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or training recognised by the RACGP as being of an equivalent standard; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard.

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

A.5.2 Items 1 to 51 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).

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 surgery consultations during an after-hours period, the medical practitioner would only use the standard after-hours attendance items (items 5000 - 5067 and 5200 - 5267) and not the items for urgent after-hours attendances at consulting rooms (items 2, 98, 448, 449, 602, 698).
- A.5.14 Paragraph A.10 of the explanatory notes provides additional information regarding the items for urgent after-hours attendances (1, 2, 97, 98, 448, 449, 601, 602, 697, 698).

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

- A.10.1 In addition to the standard after-hours attendance items (items 5000 - 5067 and 5200 - 5267) there are items for use where a patient's medical condition requires urgent treatment during an after-hours period (items 1, 2, 97, 98, 448, 449, 601, 602, 697, 698). There are items for both in-surgery and out-of-surgery consultations.
- A.10.2 The urgent after-hours items can only be used where, in the opinion of the attending practitioner, the patient has a medical condition that requires urgent treatment within the unbroken after-hours period and treatment could not be delayed until the next in-hours period. The opinion of the attending practitioner regarding a medical condition requiring urgent attendance would need to be acceptable to the general body of medical practitioners. The items are not available for non-urgent treatment that could take place during normal working hours.
- A.10.3 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.
- A.10.4 Items 1, 2, 97, 98, 448, 449, 601, 602, 697 and 698 should only be used if the following requirements are met:
- the patient's medical condition requires urgent treatment (as described at A.10.2); and
 - the attendance takes place within an after-hours period; and

- the attendance is requested by the patient or a responsible person (such as a spouse, parent, guardian or carer, but excluding the attending medical practitioner, employees of that practitioner, contractors, employees or members of the general practice where that practitioner is working at the time of the attendance and call centres and reception services associated with that practitioner/general practice); and
- the request is made within or not more than two hours before the commencement of the after-hours period in which the service is provided; and
- only for the first patient seen on that occasion. If more than one patient is seen on the one occasion the standard after-hours attendance items should be used in respect of the second and subsequent patients attended on the same occasion.

Urgent After-Hours Attendances during Unsociable Hours (449, 601, 602, 697 and 698)

A.10.5 Items 449, 601, 602, 697 and 698 are intended to allow for urgent attendances during 'unsociable' hours, that is, between 11pm and 7am on any day of the week. Apart from the time restrictions, 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.

Urgent After-Hours Attendances at Consulting Rooms (Items 2, 98, 448, 449, 602 and 698)

A.10.6 Where a practice or clinic routinely conducts surgery consultations in the after-hours period the standard after-hours attendance items (items 5000-5067 and 5200-5267) apply. The urgent after-hours consulting room items (items 2, 98, 448, 449, 602 and 698) may not be used.

A.10.7 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 urgent 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 standard after-hours surgery attendances (items 5000 - 5067 and 5200 - 5267).

Urgent After-Hours Attendances at a Place Other Than Consulting Rooms (Items 1, 97, 601 and 697)

A.10.8 Provided all conditions of the items are met, items for urgent after-hours attendances at a place other than consulting rooms (items 1, 97, 601 and 697) are available to all medical practitioners providing after-hours home visits, visits to patients in Residential Aged Care Facilities, institutions or hospitals. This includes medical practices and deputising services which routinely provide after-hours attendances.

A.10.9 Where any of the item conditions do not apply, the standard after-hours attendance items (items 5000-5067 and 5200-5267) or the normal in-hours attendance items should be used.

A.10.10 Where the patient is seen at a public hospital the following additional provisions would apply in relation to the urgent out of surgery after-hours 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.

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 Referred Patient Consultant Physician Treatment and Management Plan (Items 132 and 133)

A.12.1 Patients with at least two morbidities which can include complex congenital, development and behavioural disorders are eligible for these services when referred by their referring practitioner.

A.12.2 Item 132 should include the development of options for discussion with the patient, and family members, if present, including the exploration of treatment modalities and the development of a comprehensive consultant physician treatment and management plan, with discussion of recommendations for services by other health providers as appropriate.

A.12.3 Item 133 is available in instances where a review of the consultant physician treatment and management plan provided under item 132 is required, up to a maximum of two claims for this item in a 12 month period. Should further reviews of the consultant physician treatment and management plan be required, the appropriate item for such service/s is 116.

A.12.4 Where a patient with a GP health assessment, GP management plan or Team Care Arrangements (TCA) is referred to a consultant physician for further assessment, it is intended that the consultant physician treatment and management plan should augment the GP management plan or TCA for that patient.

A.12.5 Preparation of the consultant physician treatment and management plan should be in consultation with the patient. If appropriate, a written copy of the consultant physician treatment and management plan should be provided to the patient. A

written copy of the consultant physician treatment and management plan should be provided to the referring medical practitioner, usually within two weeks of the consultant physician consultation. In more serious cases, more prompt provision of the plan and verbal communication with the referring medical practitioner may be appropriate. A guide to the content of such consultant physician treatment and management plans which are to be provided under this item is included within this Schedule.

(Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs.)

REFERRED PATIENT CONSULTANT PHYSICIAN TREATMENT AND MANAGEMENT PLAN

- The following content outline is indicative of what would normally be sent back to the referring practitioner.
- The consultant physician treatment and management plan should address the specific questions and issues raised by the referring practitioner.

History

The consultant physician treatment and management plan should encompass a comprehensive patient history which addresses all aspects of the patient's health, including psychosocial history, past clinically relevant medical history, any relevant pathology results if performed and a review of medication and interactions. There should be a particular focus on the presenting symptoms and current difficulties, including precipitating and ongoing conditions. The results of relevant assessments by other health professionals, including GPs and/or specialists, including relevant care plans or health assessments performed by GPs under the Enhanced Primary Care and Chronic Disease Management should also be noted.

Examination

A comprehensive medical examination means a full multi-system or detailed single organ system assessment. The clinically relevant findings of the examination should be recorded in the management plan.

Diagnosis

This should be based on information obtained from the history and medical examination of the patient. The list of diagnoses and/or problems should form the basis of any actions to be taken as a result of the comprehensive assessment. In some cases, the diagnosis may differ from that stated by the referring practitioner, and an explanation of why the diagnosis differs should be included. The report should also provide a risk assessment, management options and decisions.

Management plan

Treatment options/Treatment plan

The consultant physician treatment and management plan should include a planned follow-up of issues and/or conditions, including an outline of the recommended intervention activities and treatment options. Consideration should also be given to recommendations for allied health professional services, where appropriate.

Medication recommendations

Provide 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.

Social measures

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

Other non medication measures

This may include other options such as life style changes including exercise and diet, any rehabilitation recommendations and discussion of any relevant referrals to other health providers.

Indications for review

It is anticipated that the majority of patients will be able to be managed effectively by the referring practitioner using the consultant physician treatment and management plan. If there are particular concerns about the indications or possible need for further review, these should be noted in the consultant physician treatment and management plan.

Longer term management

Provide a longer term consultant physician treatment and management plan, listing alternative measures that might be taken in the future if the clinical situation changes. This might be articulated as anticipated response times, adverse effects and interactions with the consultant physician treatment and management plan options recommended under the consultant physician treatment and management plan.

A.13 Geriatrician Referred Patient Assessment and Management Plan (Items 141-147)

Items 141 -147 apply only to services provided by a consultant physician or specialist in the specialty of Geriatric Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine.

A.13.1 Referral for Items 141-147 should be through the general practitioner for the comprehensive assessment and management of frail older patients, older than 65, with complex, often interacting medical, physical and psychosocial problems who are at significant risk of poor health outcomes. 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.13.2 A comprehensive assessment of an older person should as a minimum cover:

- current active medical problems
- past medical history;
- medication review;
- immunisation status;
- advance care planning arrangements;
- current and previous physical function including personal, domestic and community activities of daily living;
- psychological function including cognition and mood; and
- social function including living arrangements, financial arrangements, community services, social support and carer issues.

(Note: Guidance on all aspects of conducting a comprehensive assessment on an older person is available on the Australian and New Zealand Society for Geriatric Medicine website at www.anzsgm.org).

A.13.3 Some of 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 geriatrician. The remaining components of the assessment and development of the management plan must include a personal attendance by the geriatrician. *See Explanatory Note A.23.4 for requirements for a third party provider.*

A.13.4 A prioritised list of diagnoses/problems should be developed based on information provided by the history and examination, and any additional information provided by other means, including an interview of a person other than the patient.

A.13.5 The management plan should be explained and if necessary provided in written form to the patient or where appropriate, their family or carer(s).

A.13.6 A written report of the assessment including the management plan should be provided to the general practitioner within a maximum of 2 weeks of the assessment. More prompt verbal communication may be appropriate.

A.13.7 Items 143 and 147 are available in instances where the GP initiates a review of the management plan provided under items 141 and 145, usually where the current plan is not achieving the anticipated outcome. It is expected that when a management plan is reviewed, any modification necessary will be made.

A.13.8 Items 143 and 147 can be claimed once in a 12 month period. However, if there has been a significant change in the patient's clinical condition or care circumstances necessitating another review, an additional item 143 or 147 can be claimed. In these circumstances, the patient's invoice or Medicare voucher should be annotated to briefly indicate the reason why the additional review was required (e.g. annotated as clinically indicated, exceptional circumstances, significant change etc).

A.14 Prolonged Attendance in Treatment of a Critical Condition (Items 160-164)

A.14.1 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.15 Family Group Therapy (Items 170, 171, 172)

A.15.1 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.16 Acupuncture (Item 173, 193, 195, 197 and 199)

A.16.1 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.16.2 Other items in Category 1 of the Schedule should not be itemised for professional attendances when the service "acupuncture" is provided.

A.16.3 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.17 Referred Patient Assessment and Management Plan (Items 291 to 293 and 359), Initial Consultations for NEW PATIENTS (Items 296 to 299 and 361) and Referral to Allied Health Professionals (for new and continuing patients)

A.17.1 Referral for items 291, 293 and 359 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.17.2 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.17.3 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.17.4 It is expected that item 291 will be a single attendance. However, there may be particular circumstances where a patient has been referred by a GP 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, items 296, 297, 299 or 361 (for a new patient) or 300-308 (for continuing patients) may be used, and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a consultation (in accordance with the item requirements) prior to the consultation for providing the referring medical practitioner with an assessment and management plan. It is not intended that items 296, 297, 299, 361 or 300-308 will generally or routinely be used in conjunction with, or prior to, item 291.

A.17.5 Items 293 and 359 are 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, item 299 for home visits and 361 for telepsychiatry)

A.17.6 The rationale for items 296 – 299 and 361 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 items 296 – 299 and 361 may be from a medical practitioner practising in general practice, a specialist or another consultant physician.

A.17.7 It is intended that either item 296, 297, 299 or 361 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.17.8 There may be particular circumstances where a patient has been referred by a GP to a 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, 299 or 361 (for a new patient) or 300-308 (for continuing patients) may be used and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a 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, 299 or 361 will be used in conjunction with, or prior to, item 291.

A.17.9 Use of items 296 - 299 and 361 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient.

A.17.10 Items 300 - 308 are available for consultations in consulting rooms other than those provided under item 296, and items 291, 293 and 359. Similarly time tiered items remain available for hospital, home visits and telepsychiatry. These would cover a new course of treatment 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 Allied Mental Health Professionals (for new and continuing patients)

A.17.11 To increase the clinical treatment options available to psychiatrists and paediatricians for which a Medicare benefit is payable, patients with an assessed mental disorder (dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items) may be referred to an allied mental health professional for a total of twelve individual allied mental health services in a calendar year. The twelve services may consist of: psychological therapy services (items 80000 to 80015) - provided by eligible clinical psychologists; and/or focussed psychological strategies - allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165) - provided by eligible psychologists, occupational therapists and social workers. 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 referring practitioner after the initial six sessions.

A.17.12 While such referrals are likely to occur for new patients seen under items 296 – 299 and 361, they are also available for patients at any point in treatment (from items 293 to 370), as clinically required, under the same arrangements and limitations as outlined in A.17.11. There is provision for a further referral for up to an additional six individual services to be provided in exceptional circumstances. Exceptional circumstances apply where there has been a significant change in the patient's clinical condition of care circumstances which requires further allied mental health services. 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 twelve individual services permitted within a calendar year. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

A.17.13 Patients will also be eligible to claim up to twelve 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 services per calendar year maximum associated with those items.

A.18 Psychiatric Attendances (Item 319)

A.18.1 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.18.2 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.18.3 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.18.4 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.18.5 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.18.6 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.18.7 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.19 Interview of Person other than a Patient by Consultant Psychiatrist (Items 348, 350, 352)

A.19.1 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.19.2)

A.19.2 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.19.3 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.19.4 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.20 Consultant Occupational Physician attendances (Items 385 to 388)

A.20.1 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.21 Contact Lenses (Items 10801-10809)

A.21.1 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.21.2 Benefits are payable for an initial referred consultation rendered in association with the fitting and prescribing of the lenses.

A.21.3 Subsequent follow-up attendances attract benefits on a consultation basis.

A.22 Refitting of Contact Lenses (Item 10816)

A.22.1 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.23 Health Assessments (Items 700 to 706)

A.23.1 These items do not apply to in-patients of a hospital or care recipients in residential aged care facilities.

A.23.2 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.23.3 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.23.4 For the purposes of A.23.3, 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.23.5 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.23.6 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.23.7 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.23.8 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.23.9 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.23.10 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.23.11 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.23.12 Practitioners should establish a register of their patients seeking annual health assessments and remind registered patients when their next health assessment is due.

A.23.13 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.23.14 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.23.15 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.24 ABORIGINAL AND TORRES STRAIT ISLANDER CHILD HEALTH CHECK (ITEM 708)

A.24.1 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.24.2 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.24.3 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.24.4 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.24.5 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.24.6 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.24.7 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.24.8 This item does not apply to people who are in-patients of a hospital. 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.24.9 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.24.10 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.24.11 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.24.12 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.24.13 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.24.14 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.24.15 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.24.16 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.24.17 Medical practitioners should also review information contained in the patient's child health record.

Mandatory Matters

A.24.18 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.24.19 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.24.20 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.24.21 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.24.22 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.24.23 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.24.24 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.24.25 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.24.26 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.24.27 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.24.28 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.24.29 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.24.30 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.25 ABORIGINAL AND TORRES STRAIT ISLANDER ADULT HEALTH CHECK (Item 710)

A.25.1 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.25.2 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.25.3 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.25.4 Cervical cancer remains a significant cause of death in this under-screened population.

A.25.5 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.25.6 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.25.7 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.25.8 This item does not apply to people who are in-patients of a hospital 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.25.9 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.25.10 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.25.11 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.25.12 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.25.13 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.25.14 The other components of the health check must include a personal attendance by the medical practitioner.

A.25.15 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.25.16 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) the patient.

HISTORY

A.25.17 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.25.18 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.25.19 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.25.20 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.25.21 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.25.22 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.25.23 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.25.24 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.25.25 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.25.26 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.25.27 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.25.28 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.25.29 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.25.30 It is recommended that practitioners establish a register of their patients seeking a two yearly health check and remind registered patients when their next health check is due.

A.26 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.26.1 This item applies to residents of a Residential Aged Care Facility. It does not apply to in-patients of a hospital. 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.26.2 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.26.3 Where the resident has an informal or family carer (see note A.26.8 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.26.4 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.26.5 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.26.6 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.26.7 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.26.8 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.26.9 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.26.10 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.26.11 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.26.12 **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.26.13 **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.26.14 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.26.15 **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.26.16 **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.26.17 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.26.18 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.26.19 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.27 HEALTH ASSESSMENTS FOR REFUGEES AND OTHER HUMANITARIAN ENTRANTS (Items 714 and 716)

A.27.1 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.27.2 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.27.3 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.27.4 A maximum of one Medicare rebate is payable for a health assessment per refugee or other humanitarian entrant.

A.27.5 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.27.6 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.27.7 This item does not apply to in-patients of a hospital or care recipients in residential aged care facilities.

A.27.8 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.27.9 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.27.10 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.27.11 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.27.12 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.27.13 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.27.14 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.27.15 The health assessment must include keeping a record of the health assessment, and offering the patient a written report about the health assessment.

A.27.16 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.27.17 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.27.18 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.27.19 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.27.20 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.27.21 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.27.22 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.27.23 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.27.24 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.27.25 A desktop guide - Caring for Refugee Patients in General Practice - is available on the RACGP website at www.racgp.org.au.

A.28 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.28.1 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.28.2 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.28.3 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.28.4 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.28.5 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.28.6 A Medicare rebate is payable for this item only once for any eligible patient. This item is not an annual health check.

A.28.7 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.28.8 The item does not apply to admitted patients of a hospital.

Eligible practitioners

A.28.9 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.28.10 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.28.11 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.28.12 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.28.13 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.28.14 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.28.15 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 Lifescrpts resources.

Role of the GP

A.28.16 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.28.17 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.28.18 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 *Lifescrpts* guidelines and evidence cards, assessment tools and prescription pads.

Relationship with other items

A.28.19 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.28.20 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.28.21 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.29 ANNUAL HEALTH ASSESSMENT FOR PEOPLE WITH AN INTELLECTUAL DISABILITY (items 718 AND 719)

The purpose of the health assessment is to support general practitioners (GPs) to identify and address the specific clinical needs of patients who have an intellectual disability.

A.29.1 The health assessment does not apply to in-patients of a hospital or residential aged care facility.

A.29.2 For the health assessment a person will be deemed to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient (IQ)) and would benefit from assistance with daily living activities. Where GPs wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a paediatrician registered to practice in Australia or from a government-provided or funded disability service that has assessed the patient's intellectual function.

A.29.3 The aim of the health assessment is to provide a structured clinical framework for GPs to comprehensively assess the physical, psychological and social function of patients with an intellectual disability and to identify any medical intervention and preventative health care required. If an assessment identifies that a 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 for GP Management Plans and Team Care Arrangements (see items 721-731).

A.29.4 The health assessment 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.29.5 The health assessment should generally be undertaken by the patient's 'usual doctor', that is, the GP (or a GP in the same practice) who has provided the majority of services to the patient in the past 12 months, and/or is likely to provide the majority of services in the following 12 months.

A.29.6 The information collection component of the assessment may be rendered by a nurse or other health professional in accordance with accepted medical practice, acting under the supervision of the GP. The other components of the health assessment must include a personal attendance by the GP.

A.29.7 For the purposes of the previous paragraph, the services of a third party service provider such as a nurse or other health professional 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 GP, after the patient has agreed to a health assessment and to the use of a third party to collect information for the assessment;
- 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.29.8 The health assessment must include the following items as relevant to the patient:

- a) Check dental health (including dentition);
- b) Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years);
- c) Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years);
- d) Assess nutritional status (including weight and height measurements) and a review of growth and development;
- e) Assess bowel and bladder function (particularly for incontinence or chronic constipation);
- f) Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications);
 - Advise carers of the common side effects and interactions.
 - Consider the need for a formal medication review.
- g) Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations;
 - Refer to the current Australian Standard Vaccination Schedule (a National Health and Medical Research Council document) for appropriate vaccination schedules;
- h) Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day);
- i) Check whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and consider formal review if required;
- j) Consider the need for breast examination, mammography, Papanicolaou smears, testicular examination, lipid measurement and prostate assessment as for the general population;
- k) Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required;
- l) Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required;
- m) For patients diagnosed with epilepsy, review of seizure control (including anticonvulsant drugs) and consider referral to a neurologist at appropriate intervals;
- n) Screen for thyroid disease at least every two years (or yearly for patients with Down syndrome);
- o) For patients without a definitive aetiological diagnosis, consider referral to a genetic clinic every 5 years;
- p) Assess or review treatment for comorbid mental health issues;
- q) Consider timing of puberty and management of sexual development, sexual activity and reproductive health; and

- r) Consider whether there are any signs of physical, psychological or sexual abuse.
- A.29.9 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 also consider the following:

Medical

Health Problems identified

Follow up consultation should be arranged to determine further management when the assessment identifies issues requiring medical treatment such as high blood pressure, or clinical examination reveals likelihood of other potential health problem(s).

Continence

Continence problems are a major cause of reduced quality of life for people with an intellectual disability and are frequently amenable to improved management. Carers should be asked if there are problems and assessment should be directed at the underlying pathology.

Physical function

Activities of daily living

Patients are only eligible for the health assessment where they would benefit from assistance with activities of daily living. The assessment should consider the health impact of the patient's general skill levels (including independent living skills). The patient's daily activities also include access to transport.

The assessment should consider whether a referral for a formal review of activities of daily living is required. Assessment of activities of daily living is concerned with the interaction between the patient, their impairment (if any) and their environment. This would include an assessment of the patient's ability to transfer between bed, chair and toilet, attend to their personal hygiene, dress, prepare food and eat.

Psychological function

Cognition

People with intellectual disability can have dementia and it is particularly common in people with Down syndrome. Detailed diagnosis can often improve quality of life. Where problems with cognition and skill decline are clinically suspected, medical and psychiatric causes should be considered and investigated.

Mood

Depression is common in people with intellectual disability but diagnosis can be difficult. Depression should be considered where there is a history of weight change, changes in sleep habit and escalation of behavioural problems.

Behaviour

Behavioural problems are common in people with intellectual disability. With the review it is important to keep track of the patient's current behavioural status and where indicated ensure that there are systems in place that provide an objective measure of that status.

Psychiatric Symptoms

Psychiatric disorders occur more commonly in people with intellectual disability and are often more difficult to diagnose or distinguish from a reaction to that person's physical and interpersonal environment. Assessment of changes in behaviour should include consideration of psychiatric disorders.

Social function

Accommodation

The suitability of the patient's existing accommodation setting to provide the best physical and psychological health outcomes should be assessed. This should include compatibility with other residents, the capacity of carers to support the patient's health and social needs and identification of any health and safety issues for that patient.

Consultation with patient's carer

Where the patient has a carer (paid or unpaid), it is important for the practitioner to consider issues that relate to the care provided by the carer, including whether they are able to meet the health related needs of the patient. The patient's carer is an important source of information about the efficacy and side effects of medication and the patient's symptomatology.

Involving the patient's carer

Where the patient has a carer (see note above), the medical practitioner may find it useful to consider having the carer present for the assessment or components of the assessment (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. Where the provision of an assessment service involves consultation with a patient it should be read as including consultation with the patient's carer and/or representative where this is appropriate.

Involving Disability Professionals

It may be relevant to consult with disability professionals such as case managers who have responsibility for assessing and facilitating appropriate accommodation and disability support services, and psychologists who have responsibility for developing strategies to address challenging behaviour. If a patient needs but does not have such a professional involved, the practitioner should make appropriate referrals.

A.29.10 A record of the health assessment must be kept and a written report about the health assessment offered to the patient. The report must include recommendations identified during the health assessment. Where the patient has a formal carer or an informal or family carer, a copy of the report (or relevant extracts) should also be offered to the carer, with the agreement of the patient or his/her representative. Where appropriate the health assessment should be provided to the relevant disability professionals, with the agreement of the patient or where appropriate, their carer.

A.29.11 During the course of the 12 months following the assessment, the patient's GP is to review and adjust treatment of the patient as necessary, as part of normal medical care.

A.29.12 In circumstances where the patient's usual medical practitioner or practice 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 agreement of the patient or their representative).

A.29.13 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 issues that require clinically relevant diagnostic imaging or pathology services.

A.29.14 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 or is appropriate, considering the patient's disability.

A.29.15 Practitioners should establish a register of their patients seeking annual health assessments and remind registered patients when their next health assessment is due.

A.29.16 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.30 CHRONIC DISEASE MANAGEMENT ITEMS (Items 721 to 731)

A.30.1 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.30.2 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.30.3 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.30.52 for more information on transitional arrangements).

A.30.4 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.30.5 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.30.6 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.30.7 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.30.8 A GP Management Plan and Team Care Arrangements, together, broadly equate to an EPC multidisciplinary plan.

A.30.9 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.30.10 Patients may be eligible to be referred for:

- allied health services (items 10950 to 10970); and/or
- dental services (items 85011-87777);

where they are being managed by a GP under both a GP Management Plan (item 721 or review item 725) and a Team Care Arrangements (item 723 or review item 727). Residents of aged care facilities may also be eligible to be referred for allied health and/or dental services where their GP has contributed to or reviewed a care plan prepared for them by the facility (item 731). More information can be found at note M.3 for the allied health items and note A31 for the dental items.

A.30.11 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.30.12 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.30.13 and meeting the relevant requirements listed under A.30.41 and A.30.42. 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.30.44). The service must include a personal attendance by the GP with the patient, as part of Item 721.

A.30.13 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.30.14 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.30.15 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.30.50 and A.30.51).

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

A.30.16 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.30.18 and meeting the relevant requirements listed under A.30.41 and A.30.42. 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.30.44). The service must include a personal attendance by the GP with the patient as part of item 723.

A.30.17 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.30.18 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.30.19 The collaboration between the coordinating GP and participating providers at A.30.18 (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.30.20 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.30.48).

A.30.21 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.30.22 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.30.23 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.30.24 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.30.50 and A.30.51).

REVIEWING A GP MANAGEMENT PLAN – (Item 725)

A.30.25 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.30.26 and meeting the relevant requirements listed under A.30.41 and A.30.42. 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.30.44). The service must include a personal attendance by the GP with the patient, as part of item 725.

A.30.26 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.30.27 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.30.28 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.30.29 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.30.30 and meeting the relevant requirements listed under A.30.41 and A.30.42. 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.30.44). The service must include a personal attendance by the GP with the patient as part of item 727.

A.30.30 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.30.31 See A.30.19 and A.30.20 for information on collaboration and on the required number and roles of collaborating providers.

A.30.32 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.30.33 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.30.50 and A.30.51).

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.30.34 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.30.35.

A.30.35 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.30.36 See A22.19 and A.30.20 on collaboration and communication.

A.30.37 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.30.38 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.30.39 This item, including the components of the service, is similar to Item 729 (see A.30.34 to A.30.38 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.30.40 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).

In addition, patients with type 2 diabetes may also access new MBS items 81100, 81105, 81110, 81115, 81120, 81125 (Allied Health Group Services for Patients with Type 2 Diabetes) subject to patient eligibility and other restrictions.

ADDITIONAL INFORMATION

A.30.41 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.

In addition, patients with type 2 diabetes may also access new MBS items 81100, 81105, 81110, 81115, 81120, 81125 (Allied Health Group Services for Patients with Type 2 Diabetes) subject to patient eligibility and other restrictions.

A.30.42 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.30.43 For the purpose of paragraphs A.30.1 to A.30.52:

- (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.30.44 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.30.45 Patients being managed under a GPMP (Item 721) and/or TCA (Item 723) by their GP may receive ongoing support and monitoring services from practice nurses and Aboriginal Health Workers under item 10997, consistent with the scope of the plan, and for and on behalf of the GP managing the patient's chronic condition.

A.30.46 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.30.47 A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

A.30.48 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.30.49 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.30.50 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.30.51 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.30.52 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.30.53 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.31 NEW MEDICARE DENTAL ITEMS FOR PATIENTS WITH CHRONIC CONDITIONS AND COMPLEX CARE NEEDS – SERVICES PROVIDED BY A DENTAL PRACTITIONER ON REFERRAL FROM A GP

Overview

From 1 November 2007, new dental items (85011-87777) will be available to people with chronic medical conditions and complex care needs, on referral from a GP.

These new items will replace the three existing Enhanced Primary Care (EPC) dental items 10975, 10976 and 10977. See notes below – "Cessation of the EPC dental items 10975-10977".

The new items can be provided by dentists, dental specialists and dental prosthetists registered with Medicare Australia. The items are based on the dental schedules currently used by the Department of Veterans' Affairs (with some modifications).

Eligible patients can receive up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services provided over two consecutive calendar years under items 85011-87777.

The two-year period is counted from the calendar year of the patient's first eligible dental service. For example, if the patient's first dental service is on 15 November 2007, the applicable two-year period will be the 2007 and 2008 calendar years.

From 1 November 2007, patients, GPs and dental practitioners will be able to call a telephone enquiry line at Medicare Australia. They will be able to check whether the required GP care planning items have been claimed and how much the patient has received in Medicare benefits for dental services over a particular period. This will help inform patients about whether they will exceed their benefit limit of \$4,250 over the relevant two calendar year period. Patients can call the Patient Enquiry Line on 132 011. GPs or dental practitioners can call the Provider Enquiry Line on 132 150.

Terminology

The term "GP" is used as a generic reference to medical practitioners (including a GP, but not including a specialist or consultant physician) able to refer patients for eligible dental services.

The term "dental practitioner" is used as a generic reference to dentists, dental specialists and dental prosthetists.

What types of dental services are covered

The new items will cover a comprehensive range of dental services. These include dental assessments; removal of plaque and other preventive services; restorative services such as fillings, crowns, bridges and implants; extractions and other oral surgery (performed in a dentist's surgery); orthodontic services; and dentures.

The dental items can only be used whether the primary objective of the treatment is to improve oral health and function. The items cannot be claimed for treatment that is predominantly for the improvement of the appearance of the patient (eg cosmetic). Services which aim to improve the health or function of the patient, but which also comprise a cosmetic component may be claimed.

Dental items do not apply to hospital services

The items are for dental services provided in the community. The items cannot be claimed for dental treatment provided to an admitted patient in a hospital.

MBS Dental Services Book

More detailed information about items 85011 - 87777, including item descriptors, rebate levels and explanatory notes, is set out in a new MBS Dental Services Book. Information about individual items can also be accessed through www.health.gov.au/mbsonline

The MBS Dental Services Book will be distributed to dentists, dental specialists and dental prosthetists prior to 1 November 2007.

The Book is also available on request from the Department of Health and Ageing by phoning (02) 6289 4297. Alternatively, the Book can be downloaded from www.health.gov.au/epc

Informing the patient about the cost of dental services

When referring patients for dental services, GPs should inform patients that the services will not necessarily be bulk billed. Dental practitioners are free to set their own fees for services and, in some instances, patients may incur out-of-pocket costs.

To assist patients in understanding the cost of dental treatment, dental practitioners will be required to provide patients with a proposed treatment plan following an examination and assessment including any diagnostic tests. The plan must include an itemised quotation of proposed charges for future work.

Eligible patients

The dental items are targeted at patients with chronic medical conditions and complex care needs. The patient's oral health must also be impacting on, or likely to impact on, their general health.

In practice this means that, before a patient can access dental services under Medicare, the patient must have received the following services from a GP within the previous two years:

- GP Management Plan (item 721 or a review under item 725) **and** Team Care Arrangements (item 723 or a review under item 727); **or**
- for residents of an aged care facility, their GP must have contributed to or reviewed a multidisciplinary care plan prepared for the resident by the facility (item 731).

The need for dental services should be recommended in the patient's care plan. GPs are encouraged to attach a copy of the relevant part of the patient's care plan when referring the patient to a dental practitioner.

For more information on these Chronic Disease Management (CDM) care planning items, refer to the relevant explanatory notes in the MBS Book or at www.health.gov.au/mbsonline

Medicare Australia cannot pay benefits for dental services until the required GP care planning items have been claimed and paid for the patient.

Referral by a GP to a dental practitioner

If a person is eligible for dental services, a referral from a GP to a dental practitioner is required.

In most cases, the GP must refer the patient to an eligible dentist in the first instance.

In some limited cases, the GP may refer the patient directly to a dental prosthetist. This can be done where the patient has no natural teeth and requires dental prosthetic services only (eg full dentures) or requires repairs or maintenance to full or partial dentures.

Patients cannot be referred directly to a dental specialist by a GP. The dentist will decide whether a patient requires more specialised dental treatment, and where required, the dentist will make the necessary referral to a dental specialist. A dentist can also refer a patient to another dentist or a dental prosthetist if required.

New referrals

Where further dental services are required to treat a new or existing oral health problem at the end of a patient's two calendar year period, the patient will need to obtain a new referral from their GP. The patient's new two year period will be counted from the calendar year of the patient's first eligible dental service under the new referral.

Referral form

GPs must use the *Referral Form for Dental Services under Medicare* issued by the Department of Health and Ageing, or a form that substantially complies with this referral form. This new referral form will replace the Department's existing EPC referral form used for dental items 10975-10977.

The new referral form is available on request from the Department of Health and Ageing by phoning (02) 6289 4297. Alternatively, the referral form can be downloaded from www.health.gov.au/epc

Reporting by the dental practitioner to the GP

The dental practitioner must provide a copy or summary of the patient's treatment plan to the referring GP at the commencement of the course of treatment (ie following an examination and assessment of the patient, including any diagnostic tests). The dental practitioner may also provide further feedback on the patient's treatment to the referring GP at other times, where appropriate.

Cessation of the EPC dental items 10975-10977

The Enhanced Primary Care (EPC) dental items 10975-10977 will remain in place until 31 December 2007 to enable patients to complete any treatment they have already commenced under these items (if they wish). However, there is no requirement for existing patients to use all of their current entitlement of three dental services per calendar year before they can access the new dental items. Existing patients can receive dental services under the new dental items from 1 November 2007, as long as they have a new referral from their GP.

For the period 1 November 2007 to 31 December 2007:

- Any Medicare benefits paid under the EPC dental items 10975-10977 will not count towards the patient's benefit limit of \$4,250 over two consecutive calendar years for the new dental items 85011-87777.
- Any services provided under the new dental items 85011-87777 will not count towards the patient's limit of three dental services per calendar year under the EPC dental items 10975-10977.

As at 1 November 2007 (following indexation), the Medicare rebate for items 10975-10977 will be \$79.65.

A.32 Case Conferences by medical practitioners (other than specialist or consultant physician) (Items 734 to 779)

A.32.1 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 or a care recipient in a residential aged care facility.

A.32.2 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 and is not a care recipient in a residential aged care facility.

A.32.3 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.32.4 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.32.5 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.

A.32.6 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.32.7 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.32.8 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.32.4 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.32.9 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.32.10 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.32.4 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.32.11 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.32.4, A.32.8 and A.32.10. 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.32.12 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.32.13 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

A.32.14 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.32.15 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.32.16 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.33 Public Health Medicine (Items 410 to 417)

A.33.1 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.34 Case Conferences by consultant physician (Items 820 to 838)

A.34.1 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.

A.34.2 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. Items 830, 832, 834, 835, 837 and 838 are payable not more than once for each hospital admission.

A.34.3 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A.34.4 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.34.5 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.34.6 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.34.7 For the purposes of A.34.5 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.34.8 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.34.4 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.

A.34.9 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.34.10 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.34.4 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.34.11 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.34.12 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.34.13 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.34.14 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.34.15 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.34.16 It is expected that a patient would not normally require more than 5 case conferences in a 12 month period.

A.34.17 This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

A.35 Attendances by Medical Practitioners who are Sports Physicians

A.35.1 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.35.2 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.35.3 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.35.4 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.35.5 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.35.6 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.36 Medication Management Reviews

Domiciliary Medication Management Review also known as Home Medicines Review (Item 900)

A.36.1 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, or care recipients in residential aged care facilities. Patients may also refer to DMMR as *Home Medicines Review*.

A.36.2 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.36.3 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.36.4 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.36.5 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.36.6 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.36.7 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.36.8 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.36.9 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.36.10 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.36.11 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.36.12 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.36.13 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.36.14 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.36.15 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.36.16 This item is available to residents of a Residential Aged Care Facility (RACF). It is not available to in-patients of a hospital, people receiving respite care in a RACF, or people living in the community setting.

A.36.17 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.36.18 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.36.19 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.36.20 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.36.21 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.36.22 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.36.23 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.36.24 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.36.25 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.36.26 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.36.27 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.36.28 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.36.29 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.36.30 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.36.31 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.37 Taking a cervical smear from a woman who is unscreened or significantly under-screened (Items 2497 - 2509 and 2598 - 2616)

A.37.1 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.37.2 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.37.3 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.37.4 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.37.5 Vault smears are not eligible for items 2497 - 2509 and 2598 - 2616.

A.37.6 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.37.7 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.38 Completion of a cycle of care for patients with established diabetes mellitus (Items 2517 - 2526, 2620 - 2635)

A.38.1 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.38.2 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.38.3 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.38.4 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.38.5 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.38.6 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.38.7 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.38.8 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.39 Completion of the Asthma Cycle of Care (Items 2546 - 2559, 2664 - 2677)

Minimum Requirements

A.39.1 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.39.2 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.39.3 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.39.4 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.39.5 A PIP Asthma Incentive is available for completing the minimum requirements of the Asthma Cycle of Care as specified in clause A.39.1 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.40 GP Mental Health Care Items (Items 2710 to 2713)

A.40.1 This note provides information on the GP Mental Health Care items 2710, 2712, 2713. It includes an overview of the 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.40.2 The GP Mental Health Care 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 mental health items for psychiatrists (items 296 - 299), clinical psychologists (items 80000 - 80020) and allied mental health providers (items 80100 – 80170).

A.40.3 The 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.40.4 The 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.40.5 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.40.6 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.40.7 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.40.8 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.40.9 to A.40.17 and meeting the relevant requirements listed under A.40.30 to A.40.39 (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.40.9 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.40.10 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.40.11 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.40.12 *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.40.13 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.40.14 Once a GP Mental Health Care Plan has been completed and claimed on Medicare, a patient is eligible to be referred for up to twelve Medicare rebateable allied mental health services per calendar year for psychological therapy or focussed psychological strategy services (with provision for exceptional circumstances, see A.40.27 to A.40.29). Patients will also be eligible to claim up to 12 separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies).

A.40.15 When referring patients GPs should provide similar information as per normal GP referral arrangements. This could include providing a copy of the patient's GP Mental Health Care Plan, where appropriate and with the patient's agreement (see also A.40.27 to A.40.29). 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.40.16 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. For the purposes of the Medicare rebateable allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). There may be two or more courses of treatment within a patient's entitlement of up to 12 services per calendar year. The number of services that the patient is being referred for is at the discretion of the referring practitioner (eg. GP).

A.40.17 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 (former 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.

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

A.40.18 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.40.19 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.40.20 to A.40.22 and meeting the relevant requirements listed under A.40.30 to A.40.39 (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.40.20 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.40.21 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.40.22 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.40.38 – A.40.39).

GP MENTAL HEALTH CARE CONSULTATION – (Item 2713)

A.40.23 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.40.24 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.40.25 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.40.26 Consultations associated with this item must be at least 20 minutes duration.

REFERRAL

A.40.27 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 up to twelve Medicare rebateable allied mental health services 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. Services provided through ATAPS count towards the patient's entitlement of up to 12 services per calendar year.

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

A.40.28 When referring patients, GPs should provide similar information as per normal GP referral arrangements, and specifically consider including both a statement identifying that a GP Mental Health Care Plan has been completed for the patient (including, where appropriate and with the patient's agreement, attaching a copy of the patient's GP Mental Health Care Plan) and clearly identifying the specific number of sessions the patient is being referred for. 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 one or more groups of up to six sessions. The GP should consider the patient's need for the second group of sessions 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.40.29 Provisions exist which allow a further referral for up to an additional six services in a calendar year 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 (see also A.40.38 to A.40.39).

ADDITIONAL CLAIMING INFORMATION

A.40.30 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.40.31 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.40.32 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.40.33 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.40.34 A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

A.40.35 All consultations conducted as part of the GP Mental Health Care items must be rendered by the GP and include a personal attendance with the patient. 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.40.36 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.40.37 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.40.38 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. In addition, eligible patients may be referred for up to 12 individual and/or 12 group therapy Medicare rebateable allied mental health services per calendar year, with provision for referral for up to an additional 6 individual services in exceptional circumstances.

'Exceptional circumstances' apply where there has been a significant change in the patient's clinical condition or care circumstances that requires, for example:

- a new GP Mental Health Care Plan or a new Review, rather than amending the existing GP Mental Health Care Plan; or
- referral for up to 6 further individual Medicare rebateable allied mental health services in excess of the patient's calendar year limit of 12 services.

A.40.39 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).

A.41 Provision of Focussed Psychological Strategies (Items 2721 - 2727)

A.41.1 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 (former items 2574, 2575, 2577, 2578 and 2704, 2705, 2707 and 2708), a GP Mental Health Care Plan or a Psychiatrist Assessment and Management Plan.

Minimum Requirements

A.41.2 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.41.3 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.41.4 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.41.5 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.41.6 It is expected that this service would be provided only for patients who are unable to attend the practice.

Specific Focussed Psychological Strategies

A.41.7 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.41.8 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.42 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.42.1 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.42.2 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.42.3 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.42.4 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.42.5 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.42.6 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.42.7 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.42.8 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.43 Telepsychiatry

A.43.1 **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.43.2 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.43.3 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.43.4 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. Items 364 to 370 are to be claimed where face-to-face consultations are clinically indicated. 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 296 to 299, 300 to 308, 353 to 358 and 361 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.43.5 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.43.6 Geographical

Telepsychiatry items 353 to 361 are available for use when a referred patient is located in a regional, rural or remote area. A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

A.43.7 Referral to Allied Mental Health Professionals (for new and continuing patients)

– see A.17.11 and A17.12

A.43.8 Referred Patient Assessment and Management Plan review (Item 359)

Referral for item 359 should be through the GP 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. Item 359 is available in instances where the GP initiates a review of the management 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 - see A17.5 (Note: An electronic version of the Guidelines is available on the RANZCP website at www.ranzcp.org)

A.43.9 Initial Consultations for NEW PATIENTS (Item 361)

The rationale for item 361 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 item 361 may be from a medical practitioner practising in general practice, a specialist or another consultant physician. It is intended that item 361 will apply once only for each new patient on the first occasion that the patient is seen by a consultant psychiatrist. It is not generally intended that item 361 will be used in conjunction with, or prior to, item 291 (see also A17.8)

The use of items 361 and 296-299 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient.

A.44 Attendances by Medical Practitioners who are Emergency Physicians (Items 501 to 536)

A.44.1 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.44.2 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.44.3 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.44.4 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.44.5 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.

A.45 Prolonged Attendance by an Emergency Physician in Treatment of a Critical Condition (Items 519 to 536)

A.45.1 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.46 Case Conferences by Consultant Psychiatrists (855 to 866)

A.46.1 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.46.2 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.

A.46.3 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. Items 861, 864 or 866 are payable not more than once for each hospital admission.

A.46.4 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A.46.5 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.46.6 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.46.8 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.46.7 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.46.8 For the purposes of A.46.5, "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.46.9 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.46.10 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.46.11 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.46.4 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.46.12 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.46.13 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

A.46.14 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.46.15 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.47 Case conference by consultant physicians in geriatric/rehabilitation medicine (Item 880)

A.47.1 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 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.47.2 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.47.3 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.48 Attendances by Outer Metropolitan Specialist Trainees (Items 5906, 5908, 5910, 5912)

A.48.1 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.48.2 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.48.3 These attendance items cannot be used for the provision of normal aftercare refer to explanatory note T.8.7 in Category 3.

A.49 Neurosurgery Specialist Referred Consultation (Items 6007 to 6015)

A.49.1 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.49.2 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 - 6009
- (ii) Level 2 - 6011
- (iii) Level 3 - 6013
- (iv) Level 4 - 6015

A.49.3 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

A.49.4 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.

A.49.5 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. meningioma, 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)

A.49.6 Item 6013 (subsequent consultation on a patient with complex neurological conditions for the duration of between 31 to 45 mins) should involve a 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.

A.49.7 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)

A.49.8 Complex neurosurgical problems referred to in items 6013 and 6015 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.50 Cancer Care Case Conference (871-872)

A.50.1 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.51 Non-directive Pregnancy Support Counselling Service (item 4001)

A.51.1 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.51.2 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.51.3 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.51.4 The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

Patient eligibility

A.51.5 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.51.6 Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service provided.

Medicare benefits

A.51.7 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.51.8 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.51.9 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.51.10 This service may only be provided by a GP who has completed appropriate non-directive pregnancy counselling training.

OUTLINE OF PROVISIONS FOR MEDICARE BENEFITS FOR OPTOMETRIC SERVICES AND NOTES FOR GUIDANCE

O1. INTRODUCTION

O1.1 All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for services with participating optometrists. The Health Insurance Act contains legislation covering the major elements of the Medicare program.

O1.2 Responsibility for regulating the Medicare program lies with the Australian Government through the Department of Health and Ageing. Medicare Australia is responsible for consideration of applications for the acceptance of optometric undertakings and for the day to day operation of Medicare and the payment of benefits. Addresses of the Department and Medicare Australia (Medicare offices) are located at the end of these Notes.

O2. PARTICIPATION BY OPTOMETRISTS

O2.1 Medicare pays benefits for services provided by optometrists who have signed an agreement to participate in arrangements with the Commonwealth Government. This agreement is formally known as the "Common Form of Undertaking - Participating Optometrists" and is often referred to as the Participating Agreement. A copy of the Undertaking is contained in Section 3 of this book.

O2.2 An optometrist registered or licensed under a law in any State or Territory of Australia, who wishes to become a participating optometrist, is required to sign the Common Form of Undertaking and an employer of optometrists must sign a separate common form of undertaking except where the optometrist and the owner of the business are the same person.

O2.3 Where the optometric practice is conducted in a corporate form, such as a company or partnership, it is necessary for the corporation to become a "participating optometrist", and an additional undertaking must be signed by a person who has authority to give the undertaking on behalf of the organisation.

O2.4 The undertaking sets out the obligations to be met under the arrangements. Copies of the undertaking may be obtained from the Provider Liaison Section, Medicare Australia at the addresses listed at the end of these Notes.

O2.5 Where an employer of optometrists completes an undertaking, that undertaking must identify premises owned by them or in their possession. The relevant details are to be included in schedules 2 and 3 of the undertaking. An undertaking completed by an individual optometrist does not need to identify the premises from which services are to be provided as the Common Form of Undertaking applies to all premises from which the optometrists will provide services.

O2.6 When completed, the undertaking should be returned to the Manager (Eligibility), Medicare Australia, PO Box 1001, Tuggeranong, ACT 2901.

O2.7 The Minister may refuse to accept an undertaking given by an optometrist. In these circumstances the optometrist will be notified in writing of the refusal and is given 30 days to forward a written request to the Minister, to have the matter reviewed.

O2.8 After acceptance by the Minister, or his delegate, of the completed undertaking, a letter of acceptance of the undertaking will be forwarded to the optometrist. At the same time, Medicare Australia will send the optometrist a supply of assignment forms and claim forms for assignment of Medicare benefits, together with the necessary instructions for direct-billing purposes.

O2.9 The Manager (Eligibility) must be notified in writing of any changes to the details furnished by an optometrist in schedule 2 and schedule 3 of the undertaking.

O2.10 Participating optometrists may at any time terminate undertakings either wholly or as they relate to particular premises, by notifying the Manager (Eligibility), Medicare Australia, PO Box 1001, Tuggeranong ACT 2901. The date of termination may not be earlier than 30 days after the date on which the notice is served.

O2.11 The names and addresses of participating optometrists may be obtained from the Manager (Eligibility), Medicare Australia, PO Box 1001, Tuggeranong ACT 2901, if the Minister or the Minister's delegate certifies in writing that this is necessary in the public interest.

O3. PROVIDER NUMBERS

O3.1 To ensure that benefits are paid only for services provided by optometrists registered in a State or Territory of Australia, each optometrist providing services for which a Medicare benefit is payable requires an individual provider number.

O3.2 Provider numbers will be issued only to individual participating optometrists registered in a State or Territory of Australia. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.

O3.3 Provider numbers are allocated to practitioners to enable claims for Medicare benefits to be processed and cheques to be correctly drawn in favour of the practitioner where applicable. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

O3.4 Optometrists can obtain a provider number from Medicare. A separate provider number is issued for each location at which an optometrist practises and has current State/Territory registration. Provider numbers for additional practice locations may also be obtained from Medicare following confirmation of State/Territory registration. Optometrists cannot use another optometrist's provider number.

O3.5 If a practitioner wishes Medicare benefits cheques, which would normally be drawn in favour of the practitioner, to be made payable to another payee and/or another address, written authority can be given to Medicare to do this. This payment to another party is known as a pay group link. There can only be one pay group link for an individual practice location but

multiple practitioners and practice locations can be linked to one pay group. Further information on pay group links may be obtained from Medicare (addresses at the end of the Notes).

Locum Tenens

O3.6 An optometrist who has signed a Common Form of Undertaking and is to provide services at a practice location as a locum for more than 2 weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.

O3.7 If the locum is to provide services at a practice for less than 2 weeks, the locum can use their own provider number or can obtain an additional provider number for that location (see O3.4).

O3.8 Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed a Common Form of Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Undertaking. To ensure benefits are payable when a locum practises in these circumstances, the locum optometrist should:

- Check that they will be providing optometry services on behalf of a participating optometrist ie their employer has a current Common Form of Undertaking
- Notify Medicare Australia in writing, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

O3.9 Locums can direct Medicare payments to a third party eg the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider on direct bill stationery (see para O3.5,7.22).

O4. PATIENT ELIGIBILITY

Eligible persons

O4.1 For the purposes of the optometric arrangements, an eligible person is:

- A person who holds the normal Medicare card as issued to Australian residents; or
- A person who holds a Medicare card which shows "INTERIM CARD" and the period of eligibility; or
- A person who holds a Medicare card which shows "VISITOR RHCA" (Reciprocal Health Care Agreements).

Medicare cards

O4.2 An eligible person who applies to enrol in Medicare (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare Card (green in colour). Cards may be issued for individuals or families.

O4.3 Medicare cards (blue in colour), with the words "INTERIM CARD" are issued in certain circumstances to persons who have applied for permanent resident status.

O4.4 Medicare cards with the words "RECIPROCAL HEALTH CARE " are issued to visitors from countries with which Australia has Reciprocal Health Care Agreements. Visitors from New Zealand and the Republic of Ireland are **NOT** entitled to optometric treatment under RHCA and all other RHCA visitors are only entitled to immediately necessary treatment.

O5. BENEFITS FOR SERVICES BY PARTICIPATING OPTOMETRISTS

What services are covered

O5.1 The services coming within the scope of the optometric benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to consultation on ocular or vision problems or related procedures.

O5.2 Benefits may only be claimed when:

- (a) a service has been performed and a clinical record of the service has been made;
- (b) a significant consultation or examination procedure has been carried out;
- (c) the service has been performed at premises listed in an undertaking;
- (d) the service has involved the personal attendance of both the patient and the optometrist; and
- (e) the service is "clinically relevant" (as defined in the Health Insurance Act) ie a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

Where Medicare benefits are not payable

O5.3 Medicare benefits may not be claimed for attendances for:

- (a) delivery, dispensing, adjustment or repairs of visual aids;
- (b) filling of prescriptions written by other practitioners

O5.4 Benefits are not payable for optometric services associated with:

- (a) cosmetic surgery
- (b) refractive surgery
- (c) tests for fitness to undertake sporting, leisure or vocational activities
- (d) compulsory examinations or tests to obtain any commercial licence (eg flying or driving)
- (e) entrance to schools or other educational facilities
- (f) compulsory examinations for admissions to aged care facilities
- (g) vision screening

O5.5 Medicare benefits are not payable for services in the following circumstances:

- (a) where the expenses for the service are paid or payable to a recognised (public) hospital;
- (b) where the service is provided by teaching institutions to patients of supervised students;
- (c) where the service is not "clinically relevant" (as described in the Health Insurance Act, ie a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered).

O5.6 Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric service where:

- (a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory; or
- (b) the service was rendered in one or more of the following circumstances –
 - (i) the employer arranges or requests the consultation
 - (ii) the results are provided to the employer by the optometrist
 - (iii) the employer requires that the employee have their eyes examined
 - (iv) the account for the consultation is sent to the employer
 - (v) the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's workplace.

Services rendered to an optometrist's dependants, employer or practice partner or dependants

O5.7 A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to his or her employer or practice partner or any dependants of that employer or partner.

6. SCHEDULE FEES AND MEDICARE BENEFITS

Schedule fees and Medicare benefits

O6.1 Optometrists participating in the scheme agree not to charge more than the Schedule fees for services covered by Medicare, and also, that charges for appliances shall not include any amount related to consultation procedures for which benefits are payable. The only exceptions are for Item 10907 and in relation to domiciliary visits - see paragraphs O6.13 and O6.19 – O6.26.

O6.2 The services provided by participating optometrists which attract benefits are set out in the Health Insurance Regulations. Details of the services, including the Schedule fee and Medicare benefits for each service are contained in Section 2 of this book.

O6.3 Medicare benefits are payable at 85% of the Schedule fee for services rendered with a maximum gap payment for any one service of \$61.50 (indexed annually) between the Medicare rebate and the Schedule fee.

O6.4 Where it can be established that payments of \$358.90 (effective from 1 January 2007 and indexed annually from 1 January each year) have been made by a family or an individual during a calendar year regarding the difference between the Medicare benefit and the Schedule fee for out-of-hospital services, benefits will thereafter be paid for the rest of that year up to 100% of the Schedule fee. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

Limiting rule for patient claims

O6.5 Where a fee charged for a service is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances

O6.6 Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the services before they can be regarded as separate attendances.

O6.7 Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (eg 10.30 am and 3.15 pm) in order to assist in the payment of benefits, except where a perimetry item is performed in association with a consultation item where times do not need to be specified.

O6.8 In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Referred comprehensive initial consultations (Item 10905) - Read in conjunction with 09.1 - 09.13

O6.9 For the purposes of Item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

O6.10 Benefits will be paid at the level of Item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist. Referrals from medical practitioners do not attract benefit under item 10905.

O6.11 The optometrist claiming the Item 10905 service is obliged to retain the written referral for a period of twenty-four months.

O6.12 Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation within 24 months of a previous comprehensive consultation (Item 10907)

O6.13 Where a patient receives a comprehensive initial consultation within 24 months of a previous comprehensive consultation provided by another optometrist an additional fee may be charged provided that the service is not direct-billed. The actual additional amount charged is a matter between the optometrist and the patient but it must not exceed an amount equal to the difference between the Schedule fees for Item 10900 and Item 10907.

O6.14 In circumstances where an additional fee is charged the optometrist must inform the patient of the benefit payable for Item 10907 at the time of the consultation and that the additional fee will not attract benefits.

O6.15 Where it is necessary for the optometrist to seek patient information from Medicare in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:-

- (a) the patient is advised of the need to seek the information and the reason the information is required;
- (b) the patient's informed consent to the release of information has been obtained; and
- (c) the patient's records verify the patient's consent to the release of information.

Significant change in visual function requiring comprehensive re-evaluation (Item 10912)

O6.16 Significant changes in visual function which justify the charging of Item 10912 include documented changes of:

- vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)
- visual fields or previously undetected field loss
- binocular vision
- contrast sensitivity or previously undetected contrast sensitivity loss.

New Signs or symptoms/progressive disorder requiring comprehensive re-evaluation (Items 10913 and 10914)

O6.17 When charging Item 10913 and Item 10914, the optometrist must document the new signs or symptoms or the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (Item 10915)

O6.18 Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Domiciliary visits

O6.19 Where patients are unable to travel to an optometrist's practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist travelling to the patient's place of residence, transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

O6.20 Benefits are payable under items 10931 – 10933 to provide some financial assistance in the form of a loading to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The loading is in addition to the consultation item. For the purposes of the loading, acceptable places of residence for domiciliary visits are the patient's home, a residential aged care facility as defined by the *Aged Care Act 1997*, or an institution which means a place (other than a residential aged care facility or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

O6.21 Visits to a hospital are not covered by the new loading, but are covered by the previous arrangements, that is, where a visit to a hospital is provided at the patient's request, an extra fee not exceeding the fee for item 10900 may be charged, in addition to the Schedule fee, providing the service is not bulk-billed. Benefits are not payable in respect of the private charge.

O6.22 Items 10931 – 10933 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the loading is also, and no private charge can then be levied. If the consultation is not bulk-billed, the loading should also not be bulk-billed and a private charge may be levied. The additional private charge must be calculated so that the **total** charges for the basic service, loading and private charge do not exceed an amount which equals twice the fee for item 10900. The usual requirement that the patient must have requested the domiciliary visit applies.

06.23 The choice of appropriate item in the range 10931 - 10933 depends on how many patients are seen at the one location. Benefits are payable under item 10931 where the optometrist travels to see one patient at a single location. Item 10931 can be billed in addition to the consultation item. If the optometrist goes on to see another single patient **at a different location**, that patient can also be billed an item 10931 plus the consultation. However, if two patients are visited at a single location on the same occasion, each of the two patients should be billed item 10932 as well as the consultation item applying to each patient. Similarly, if three patients are visited at a single location on the same occasion, each of the three patients should be billed item 10933 as well as the consultation item applying to each patient.

06.24 Where more than three patients are seen at the same location, additional benefits for domiciliary visits are not payable for the fourth, fifth etc patients. On such occasions, the first three patients should be billed item 10933 as well as the appropriate consultation item, and all subsequent patients may only be billed the appropriate consultation item. Where multiple patients are seen at one location on one occasion, there is no provision for patients to be 'grouped' into twos and threes for billing purposes.

06.25 Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Benefits are not payable in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on accounts issued by optometrists and must not be included in the fees for the service (refer paragraph O7.11).

06.26 Domiciliary visit loading items may not be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941.

Release of prescription

06.27 Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by a person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.

06.28 Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process.

Reminder notices

06.29 The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery

06.30 Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient. The aftercare period includes all post-operative treatment, whether provided by a medical practitioner or an optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

06.31 The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.

06.32 Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and receipt issued to the patient should clearly indicate the fee is non-rebatable.

Computerised Perimetry Services (Items 10940 and 10941)

06.33 Benefit under items 10940 and 10941 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (item 10940) or one eye (item 10941) where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain. Item 10940 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 10941 for unilateral procedures should be claimed, where appropriate.

06.34 These items can be billed either in association with comprehensive consultation items 10900, 10905, 10907, 10912, 10913, 10914 or 10915, or independently, but they cannot be billed with items 10916 or 10918. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed results of the perimetry should be provided to the ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of 2 perimetry services in any 12 month period may be provided.

Low Vision Assessment (Item 10942)

06.35 A benefit is payable under item 10942 where one or more of the tests outlined in the item description are carried out on a patient who has already been established during a comprehensive consultation as having low vision, as specifically defined in the item. This item is not intended for patients expected to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

06.36 Item 10942 may be claimed on the same day as either a comprehensive initial consultation or a subsequent consultation, but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation, or with any of the contact lens items.

Children's vision assessment (Item 10943)

O6.37 Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

O6.38 A benefit is payable under item 10943 where one or more of the assessment and testing procedures outlined in the item description are carried out on a patient aged 3 - 14 years inclusive, and where a finding of significant binocular or accommodative dysfunction is the outcome of the consultation and assessment/testing. The conditions to be assessed under this item are primarily amblyopia and strabismus, but dysfunctions relating to vergences are also covered, providing well established and evidence based optometry practice is observed.

O6.39 A benefit is not payable under item 10943 for the assessment of learning difficulties or learning disabilities.

O6.40 Item 10943 may be claimed on the same day as either a comprehensive consultation or a subsequent consultation, but only where the additional assessment/testing has been carried out on an eligible child. Item 10943 is not intended to be claimed with a brief initial consultation, or with any of the contact lens items.

O7. BILLING PROCEDURES

O7.1 There are three ways benefits may be paid for optometric services:

- (a) the patient may pay the optometrist's account and then claim benefits from a Medicare office by submitting the account and the receipt;
- (b) the patient may submit the unpaid account to Medicare which will then draw a cheque in favour of the optometrist;
or
- (c) the optometrist may bill Medicare instead of the patient for the consultation. This mechanism is known as direct billing. If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Note: Additional charges must not be levied in respect of domiciliary visits and consultations covered by Item 10907 if the services are direct-billed.

Claiming of benefits

O7.2 The patient, upon receipt of an optometrist's account, has two courses open for paying the account and receiving benefits.

Paid accounts

O7.3 If the account has been paid, the claimant can obtain a cash benefit (up to certain limits) from a Medicare office. Alternatively they may lodge a claim by post, by fax in selected pharmacies and Rural Transaction Centres, or telephone (in rural areas throughout Australia) for a payment by Electronic Funds Transfer (EFT) or cheque.

Unpaid accounts

O7.4 Where the patient has not paid the account the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the optometrist.

O7.5 It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist cheques" involving Medicare benefits cannot be sent direct to optometrists, or to patients at an optometrist's address (even if requested by the patient to do so). "Pay optometrist cheques" will be forwarded to the patient's normal address.

O7.6 When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist cheque" the optometrist should indicate on the receipt that a "Medicare" cheque for \$..... was involved in the payment of the account.

Itemised accounts

O7.7 When an optometrist bills a patient for a service, the patient should be issued with a properly itemised account and receipt to enable him/her to claim Medicare benefits. Where both a consultation and computerised perimetry occur, these may be itemised on the same account.

O7.8 Medicare benefits are not payable in respect of an optometric 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 each service to each patient, the following information:-

- (a) patient's name;
- (b) date on which the service(s) was rendered;
- (c) a description of the service(s) (eg "initial consultation, "subsequent consultation" or "contact lens consultation" and/or "computerised perimetry" in those cases where it is performed);
- (d) Medicare Benefits Schedule item number(s);
- (e) the name and practice address or name and provider number of the optometrist who actually rendered the service(s). Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service(s) was given;
- (f) the fee charged for the service(s);
- (g) the time each service began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item, except where a perimetry item is performed in association with a consultation item, where times do not need to be specified.

O7.9 The optometrist billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the optometrist.

O7.10 Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered optometrist practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the optometrist's provider number are included on accounts, receipts and assignment forms.

O7.11 Details of any charges made other than for services, eg a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.

O7.12 Patients must be eligible to receive Medicare benefits and must also meet the clinical requirements outlined in the relevant item descriptors.

Duplicate accounts

O7.13 Only one original itemised account per service should be issued, except in circumstances where both a consultation and computerised perimetry occur, in which case these may be itemised on the same original account. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (direct billing) arrangements

O7.14 Under the Health Insurance Act an Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

O7.15 If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- the patient's Medicare 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.

Use of Medicare cards in direct billing

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

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

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

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

07.20 It is important for the optometrist to check the eligibility of patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement.

Assignment of benefit forms

07.21 Only the approved forms available from Medicare Australia can be used to direct bill patients for optometric services and no other form can be used without its approval.

(a) **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 comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy.

(b) **Form DB4**

This is a continuous stationery version of Form DB2 and has been designed for use on most office accounting machines.

The Claim for Assigned Benefits (Form DB1N, DB1H)

07.22 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.

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

07.24 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.

Time limits applicable to lodgement of claims for Medicare benefits

07.25 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.

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

08. LIMITATIONS ON BENEFITS

Single Course of Attention

08.1 A reference to a single course of attention means:-

- (a) In the case of Items 10900 to 10918 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.
- (b) In relation to Items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses.

Initial consultations

08.2 The initial consultation item (Item 10900) is payable once only within 24 months of the previous standard consultation (Item 10900, 10905, 10907, 10912, 10913, 10914 or 10915). However, a benefit is payable under Item 10912, 10913, 10914 or 10915 where the patient has an ocular condition which necessitates a further course of attention being started within 24 months of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items (see paragraphs 06.16, 06.17 and 06.18).

O8.3 Where an attendance would have been covered by Item 10900,10905, 10907, 10912, 10913, 10914 or 10915 but is of 15 minutes duration or less, Item 10916 (Short consultation) applies.

Second or subsequent consultations (Item 10918)

O8.4 Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by Item 10918.

Contact lens consultations (Items 10921 to 10930)

O8.5 In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in Items 10921 to 10929.

For claims under Items 10921,10922,10923,10925 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

O8.6 Medicare benefits are not payable for Item 10929 in circumstances where patients want contact lenses for:

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

O8.7 All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under Items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. Any visits related to the prescribing and fitting of lenses are regarded to be covered by the relevant item in the range 10921 to 10930. The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses. Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not Items 10921 to 10930).

O8.8 For patients not eligible for Medicare rebates for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item number should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".

O8.9 Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

O8.10 When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.

O8.11 Benefit under Items 10921-10929 is payable once only in any period of 36 consecutive months except where circumstances are met under Item 10930 within a 36 month period.

Additional payments for optometrists visiting isolated areas (the Visiting Optometrists Scheme)

O8.12 Special arrangements exist under the provisions of Section 129A of the Health Insurance Act to enable optometrists who visit isolated areas where optometric services are not otherwise available to provide services without additional charge to patients. Optometrists are particularly encouraged to provide these services to Aboriginal and Torres Strait Islander communities in remote areas.

O8.13 Under these arrangements, assistance may be provided in the form of per capita payments directly related to the numbers of patients attended, with individual rates approved for each applicant who meets the criteria for assistance, in respect of visits to specified locations.

O8.14 This assistance is provided because the participating nature of the benefit arrangements does not permit optometrists to charge fees higher than Medicare Schedule fees to offset the additional costs involved in visiting remote areas.

O8.15 Visiting optometrists may obtain application forms for such assistance from the State Manager, Australian Government Department of Health and Ageing. Addresses of State offices are located at the end of these Notes.

O8.16 Visiting optometrists should also note that Regional Eye Health Coordinators located in several Aboriginal Community Controlled Health Services in each State and Territory may be able to assist in arranging and establishing ongoing visits. Optometrists are advised to contact their State Office of the Australian Government Department of Health and Ageing.

O9. REFERRALS (Read in connection with O6.9 to O6.12)

General

O9.1 Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

O9.2 Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate.

O9.3 Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.

O9.4 A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefit at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the unreferred rate.

O9.5 Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See paragraph O9.15 regarding emergency situations.

What is a referral

O9.6 For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

O9.7 Subject to the exceptions in paragraph O9.8 below, for a valid "referral" to take place:

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

O9.8 The exceptions to the requirements in paragraph O9.7 are that:

- (a) sub-paragraphs (ii) and (iii) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see para O9.15); and
- (b) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid

O9.9 A referral from an optometrist to an ophthalmologist is valid for 12 months unless the optometrist specifies on the referral that the referral is for a different period (eg 3, 6 or 18 months or valid indefinitely).

O9.10 The referral applies for the period specified in the referral from the date that the ophthalmologist provides the first service to the patient. If there is no period specified in the referral then the referral is valid for 12 months from the date of the first service provided by the ophthalmologist.

O9.11 Referrals for longer than 12 months should be made only when the patient's clinical condition requires continuing care and management

O9.12 An optometrist may write a new referral when a patient presents with a condition unrelated to the condition for which the previous referral to an ophthalmologist was written. In these circumstances Medicare benefits for the consultation with the ophthalmologist would be payable at initial consultation rates.

O9.13 A new course of treatment for which Medicare benefits would be payable at the initial consultation rates will also be paid where the referring optometrist:-

- (a) deems it necessary for the patient's condition to be reviewed; and
- (b) the patient is seen by the ophthalmologist outside the currency of the previous referral; and
- (c) the patient was last seen by the specialist ophthalmologist more than 9 months earlier the attendance following a new referral.

Self referral

O9.14 Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Emergency situations

O9.15 Medicare benefits are payable even though there is no written referral in an emergency situation (as defined in the regulations). The specialist or the consultant physician should be of the opinion that the service must be rendered as quickly as possible and endorses the account, receipt or assignment form "Emergency referral".

O9.16 A referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist if attendances subsequent to the emergency attendance are to attract Medicare benefits at the referred rate.

O10. PROVISION FOR REVIEW AND INQUIRY

Optometric Benefits Consultative Committee (OBCC)

O10.1 The OBCC is an advisory committee established in 1990 by arrangement between the Minister and Optometrists Association Australia.

O10.2 The OBCC's functions are:

- (a) to consider the appropriateness of existing Medicare Benefits Schedule items, including the need to combine, delete or create items, and the need to amend item descriptions;
- (b) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;

- (c) to provide a forum for discussion on fees and fee relativities for individual optometric items in the Medicare Benefits Schedule (but not so as to involve a general review of the overall level of optometric fees);
- (d) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the Health Insurance Act and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;
- (e) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

O10.3 The OBCC comprises two representatives from the Department of Health and Ageing, two representatives from Medicare Australia, and three representatives from Optometrists Association Australia.

Professional Services Review (PSR) Scheme

O10.4 The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). A health practitioner is a medical practitioner, a dentist, an optometrist, a chiropractor, physiotherapist or a podiatrist.

O10.5 Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude 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.

O10.6 Medicare Australia monitors health practitioners' claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, Medicare Australia can request that the Director of PSR review the provision of services by the practitioner.

O10.7 From 1 January 2003, changes were introduced to clarify each stage in the PSR process, and to strengthen the procedural fairness provisions available to the person under review.

O10.8 The revised PSR arrangements apply in relation to requests by Medicare Australia to the Director of PSR made after 1 January 2003.

O11 PENALTIES AND LIABILITIES

Penalties

O11.1 Penalties of up to \$10,000 or imprisonment for up to five years may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used in connection with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

O11.2 A penalty of up to \$1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without necessary details having been entered on the form before the patient signs or who fails to give the patient a copy of the completed form.

Medicare Participation Review Committee (MPRC)

O11.3 The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who has been successfully prosecuted for defrauding Medicare.

O11.4 The Committees have a discretionary range of options from taking no action against the practitioner through counselling and reprimand to full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

FEES AND BENEFITS FOR GP ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A RESIDENTIAL AGED CARE FACILITY

LEVEL A		
PATIENTS	FEE/100% BENEFIT	100%
ONE	\$56.35	\$56.35
TWO	\$35.65	\$35.65
THREE	\$28.80	\$28.80
FOUR	\$25.35	\$25.35
FIVE	\$23.25	\$23.25
SIX	\$21.90	\$21.90
SEVEN+	\$18.00	\$18.00

LEVEL B		
PATIENTS	FEE/100% BENEFIT	100%
ONE	\$74.15	\$74.15
TWO	\$53.45	\$53.45
THREE	\$46.60	\$46.60
FOUR	\$43.15	\$43.15
FIVE	\$41.05	\$41.05
SIX	\$39.70	\$39.70
SEVEN+	\$35.80	\$35.80

LEVEL C		
PATIENTS	FEE/100% BENEFIT	100%
ONE	\$103.65	\$103.65
TWO	\$82.95	\$82.95
THREE	\$76.10	\$76.10
FOUR	\$72.65	\$72.65
FIVE	\$70.55	\$70.55
SIX	\$69.20	\$69.20
SEVEN+	\$65.30	\$65.30

LEVEL D		
PATIENTS	FEE/100% BENEFIT	100%
ONE	\$133.05	\$133.05
TWO	\$112.35	\$112.35
THREE	\$105.50	\$105.50
FOUR	\$102.05	\$102.05
FIVE	\$99.95	\$99.95
SIX	\$98.60	\$98.60
SEVEN+	\$94.70	\$94.70

FEES AND BENEFITS FOR OTHER NON-REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A RESIDENTIAL AGED CARE FACILITY

BRIEF		
PATIENTS	FEE/100% BENEFIT	100%
ONE	\$36.45	\$36.45
TWO	\$22.45	\$22.45
THREE	\$17.80	\$17.80
FOUR	\$15.50	\$15.50
FIVE	\$14.10	\$14.10
SIX	\$13.15	\$13.15
SEVEN+	\$9.75	\$9.75

STANDARD		
PATIENTS	FEE/100% BENEFIT	100%
ONE	\$47.55	\$47.55
TWO	\$31.75	\$31.75
THREE	\$26.50	\$26.50
FOUR	\$23.90	\$23.90
FIVE	\$22.30	\$22.30
SIX	\$21.25	\$21.25
SEVEN+	\$17.25	\$17.25

LONG		
PATIENTS	FEE/100% BENEFIT	100%
ONE	\$63.45	\$63.45
TWO	\$49.45	\$49.45
THREE	\$44.80	\$44.80
FOUR	\$42.50	\$42.50
FIVE	\$41.10	\$41.10
SIX	\$40.15	\$40.15
SEVEN+	\$36.75	\$36.75

PROLONGED		
PATIENTS	FEE/100% BENEFIT	100%
ONE	\$85.45	\$85.45
TWO	\$71.45	\$71.45
THREE	\$66.80	\$66.80
FOUR	\$64.50	\$64.50
FIVE	\$63.10	\$63.10
SIX	\$62.15	\$62.15
SEVEN+	\$58.75	\$58.75

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

LEVEL A		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$37.95	\$28.50
TWO	\$26.45	\$19.85
THREE	\$22.65	\$17.00
FOUR	\$20.75	\$15.60
FIVE	\$19.60	\$14.70
SIX	\$18.80	\$14.10
SEVEN+	\$16.70	\$12.55

LEVEL B		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$55.75	\$41.85
TWO	\$44.25	\$33.20
THREE	\$40.45	\$30.35
FOUR	\$38.55	\$28.95
FIVE	\$37.40	\$28.05
SIX	\$36.60	\$27.45
SEVEN+	\$34.50	\$25.90

LEVEL C		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$85.25	\$63.95
TWO	\$73.75	\$55.35
THREE	\$69.95	\$52.50
FOUR	\$68.05	\$51.05
FIVE	\$66.90	\$50.20
SIX	\$66.10	\$49.60
SEVEN+	\$64.00	\$48.00

LEVEL D		
PATIENTS	FEE/100% BENEFIT	75%
ONE	\$114.65	\$86.00
TWO	\$103.15	\$77.40
THREE	\$99.35	\$74.55
FOUR	\$97.45	\$73.10
FIVE	\$96.30	\$72.25
SIX	\$95.50	\$71.65
SEVEN+	\$93.40	\$70.05

FEES AND BENEFITS FOR OTHER NON-REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A 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 AN INSTITUTION OR HOME**

LEVEL A		
PATIENTS	FEE	BENEFITS 100%
ONE	\$48.60	\$48.60
TWO	\$37.10	\$37.10
THREE	\$33.30	\$33.30
FOUR	\$31.40	\$31.40
FIVE	\$30.25	\$30.25
SIX	\$29.45	\$29.45
SEVEN+	\$27.35	\$27.35

LEVEL B		
PATIENTS	FEE	BENEFITS 100%
ONE	\$66.40	\$66.40
TWO	\$54.90	\$54.90
THREE	\$51.10	\$51.10
FOUR	\$49.20	\$49.20
FIVE	\$48.05	\$48.05
SIX	\$47.25	\$47.25
SEVEN+	\$45.15	\$45.15

LEVEL C		
PATIENTS	FEE	BENEFITS 100%
ONE	\$95.85	\$95.85
TWO	\$84.35	\$84.35
THREE	\$80.55	\$80.55
FOUR	\$78.65	\$78.65
FIVE	\$77.50	\$77.50
SIX	\$76.70	\$76.70
SEVEN+	\$74.60	\$74.60

LEVEL D		
PATIENTS	FEE	BENEFITS 100%
ONE	\$125.30	\$125.30
TWO	\$113.80	\$113.80
THREE	\$110.00	\$110.00
FOUR	\$108.10	\$108.10
FIVE	\$106.95	\$106.95
SIX	\$106.15	\$106.15
SEVEN+	\$104.05	\$104.05

**FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES (OTHER THAN
CONSULTING ROOMS) AT AN 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

AFTER HOURS ATTENDANCES

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

LEVEL A		
PATIENTS	FEE	BENEFITS 100%
ONE	\$67.00	\$67.00
TWO	\$46.30	\$46.30
THREE	\$39.45	\$39.45
FOUR	\$36.00	\$36.00
FIVE	\$33.90	\$33.90
SIX	\$32.55	\$32.55
SEVEN+	\$28.65	\$28.65

LEVEL B		
PATIENTS	FEE	BENEFITS 100%
ONE	\$84.80	\$84.80
TWO	\$64.10	\$64.10
THREE	\$57.25	\$57.25
FOUR	\$53.80	\$53.80
FIVE	\$51.70	\$51.70
SIX	\$50.35	\$50.35
SEVEN+	\$46.45	\$46.45

LEVEL C		
PATIENTS	FEE	BENEFITS 100%
ONE	\$114.25	\$114.25
TWO	\$93.55	\$93.55
THREE	\$86.70	\$86.70
FOUR	\$83.25	\$83.25
FIVE	\$81.15	\$81.15
SIX	\$79.80	\$79.80
SEVEN+	\$75.90	\$75.90

LEVEL D		
PATIENTS	FEE	BENEFITS 100%
ONE	\$143.70	\$143.70
TWO	\$123.00	\$123.00
THREE	\$116.15	\$116.15
FOUR	\$112.70	\$112.70
FIVE	\$110.60	\$110.60
SIX	\$109.25	\$109.25
SEVEN+	\$105.35	\$105.35

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

BRIEF		
PATIENTS	FEE	BENEFITS 100%
ONE	\$46.45	\$46.45
TWO	\$32.45	\$32.45
THREE	\$27.80	\$27.80
FOUR	\$25.50	\$25.50
FIVE	\$24.10	\$24.10
SIX	\$23.15	\$23.15
SEVEN+	\$19.75	\$19.75

STANDARD		
PATIENTS	FEE	BENEFITS 100%
ONE	\$57.55	\$57.55
TWO	\$41.75	\$41.75
THREE	\$36.50	\$36.50
FOUR	\$33.90	\$33.90
FIVE	\$32.30	\$32.30
SIX	\$31.25	\$31.25
SEVEN+	\$27.25	\$27.25

LONG		
PATIENTS	FEE	BENEFITS 100%
ONE	\$73.45	\$73.45
TWO	\$59.45	\$59.45
THREE	\$54.80	\$54.80
FOUR	\$52.50	\$52.50
FIVE	\$51.10	\$51.10
SIX	\$50.15	\$50.15
SEVEN+	\$46.75	\$46.75

PROLONGED		
PATIENTS	FEE	BENEFITS 100%
ONE	\$95.45	\$95.45
TWO	\$81.45	\$81.45
THREE	\$76.80	\$76.80
FOUR	\$74.50	\$74.50
FIVE	\$73.10	\$73.10
SIX	\$72.15	\$72.15
SEVEN+	\$68.75	\$68.75

Services that attract the 100% Medicare rebate – as at 1 November 2007

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, 718, 719
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,
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
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, 10997, 10998, 10999

ATTENDANCES		GENERAL PRACTITIONER
GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
URGENT ATTENDANCES - AFTER HOURS		
	URGENT ATTENDANCE AFTER HOURS (on not more than 1 patient on 1 occasion)	
	Professional attendance AT A PLACE OTHER THAN CONSULTING ROOMS , by a general practitioner on not more than 1 patient on the 1 occasion – each attendance (<i>other than an attendance between 11pm and 7am</i>) in an after-hours period, if: <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and b) the patient's medical condition requires urgent treatment 	
‡ 1	(See para A.5 and A.10 of explanatory notes to this Category) Fee: \$114.95 Benefit: 75% = \$86.25 100% = \$114.95	
	Professional attendance AT CONSULTING ROOMS , by a general practitioner on not more than 1 patient on the 1 occasion – each attendance (<i>other than an attendance between 11pm and 7am</i>) in an after-hours period, if: <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and b) the patient's medical condition requires urgent treatment; and c) it is necessary for the practitioner to <i>return to, and specially open, consulting rooms</i> for the attendance 	
‡ 2	(See para A.5 and A.10 of explanatory notes to this Category) Fee: \$114.95 Benefit: 100% = \$114.95	
	Professional attendance AT A PLACE OTHER THAN CONSULTING ROOMS , by a general practitioner on not more than 1 patient on the 1 occasion – each attendance <i>between 11pm and 7am</i> , if: <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and b) the patient's medical condition requires urgent treatment 	
‡ 601	(See para A.5 and A.10 of explanatory notes to this Category) Fee: \$135.45 Benefit: 75% = \$101.60 100% = \$135.45	
	Professional attendance AT CONSULTING ROOMS , by a general practitioner on not more than 1 patient on the 1 occasion – each attendance <i>between 11pm and 7am</i> , if: <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and b) the patient's medical condition requires urgent treatment; and c) it is necessary for the practitioner to <i>return to, and specially open, consulting rooms</i> for the attendance 	
‡ 602	(See para A.5 and A.10 of explanatory notes to this Category) Fee: \$135.45 Benefit: 100% = \$135.45	
GENERAL PRACTITIONER ATTENDANCES		
	LEVEL 'A'	
	Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	
	SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.5 of explanatory notes to this Category)	
3	Fee: \$15.00 Benefit: 100% = \$15.00	
	HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) (See para A.5 of explanatory notes to this Category)	
+ 4	Derived Fee: The fee for item 3, plus \$22.95 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 \$1.70 per patient.	

ATTENDANCES		GENERAL PRACTITIONER
+ 13	<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 (See para A.5 and A.6 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 3, plus \$22.95 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 \$1.70 per patient.</p>	
+ 19	<p>CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient (See para A.5 and A.7 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 3, plus \$22.95 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 \$1.70 per patient.</p>	
+ 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 (See para A.5 and A.8 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 3, plus \$41.35 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 \$3.00 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) (See para A.5 of explanatory notes to this Category)</p> <p>Fee: \$32.80 Benefit: 100% = \$32.80</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) (See para A.5 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 23, plus \$22.95 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 \$1.70 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 (See para A.5 and A.6 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 23, plus \$22.95 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 \$1.70 per patient.</p>	
+ 33	<p>CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient (See para A.5 and A.7 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 23, plus \$22.95 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 \$1.70 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 (See para A.5 and A.8 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 23, plus \$41.35 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 \$3.00 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) (See para A.5 of explanatory notes to this Category)</p> <p>Fee: \$62.30 Benefit: 100% = \$62.30</p>	

ATTENDANCES

GENERAL PRACTITIONER

+ 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) (See para A.5 of explanatory notes to this Category) Derived Fee: The fee for item 36, plus \$22.95 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 \$1.70 per patient.</p>
+ 38	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient (See para A.5 and A.6 of explanatory notes to this Category) Derived Fee: The fee for item 36, plus \$22.95 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 \$1.70 per patient.</p>
+ 40	<p>CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient (See para A.5 and A.7 of explanatory notes to this Category) Derived Fee: The fee for item 36, plus \$22.95 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 \$1.70 per patient.</p>
+ 43	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient (See para A.5 and A.8 of explanatory notes to this Category) Derived Fee: The fee for item 36, plus \$41.35 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 \$3.00 per patient.</p>
44	<p style="text-align: center;">LEVEL 'D'</p> <p>Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.5 of explanatory notes to this Category) Fee: \$91.70 Benefit: 100% = \$91.70</p>
+ 47	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) (See para A.5 of explanatory notes to this Category) Derived Fee: The fee for item 44, plus \$22.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$1.70 per patient.</p>
+ 48	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient (See para A.5 and A.6 of explanatory notes to this Category) Derived Fee: The fee for item 44, plus \$22.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$1.70 per patient.</p>
+ 50	<p>CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient (See para A.5 and A.7 of explanatory notes to this Category) Derived Fee: The fee for item 44, plus \$22.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$1.70 per patient.</p>
+ 51	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient (See para A.5 and A.8 of explanatory notes to this Category) Derived Fee: The fee for item 44, plus \$41.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$3.00 per patient.</p>

ATTENDANCES		OTHER NON-REFERRED
	CONSULTATION AT A HOSPITAL	
	(Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient	
87	<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>	
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY	
	(Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) - each patient	
+ 92	<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 \$27.95 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 \$1.25 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 \$31.55 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 \$1.25 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 \$27.95 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 \$1.25 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 \$27.95 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 \$1.25 per patient</p>	
	URGENT ATTENDANCE - AFTER HOURS	
‡ 97	<p>Professional attendance AT A PLACE OTHER THAN CONSULTING ROOMS by a medical practitioner (other than a general practitioner) on not more than 1 patient on the 1 occasion – each attendance (<i>other than an attendance between 11pm and 7am</i>) in an after-hours period if:</p> <ol style="list-style-type: none"> the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and the patient's medical condition requires urgent treatment <p>(See para A.10 of explanatory notes to this Category) Fee: \$100.10 Benefit: 75% = \$75.10 100% = \$100.10</p>	

ATTENDANCES

OTHER NON-REFERRED

<p>‡ 98</p>	<p>Professional attendance AT CONSULTING ROOMS, by a medical practitioner (other than a general practitioner) on not more than 1 patient on the 1 occasion – each attendance (<i>other than an attendance between 11pm and 7am</i>) in an after-hours period, if:</p> <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and b) the patient's medical condition requires urgent treatment; and c) it is necessary for the practitioner to return to, and specially open, consulting rooms for the attendance <p>(See para A.10 of explanatory notes to this Category) Fee: \$100.10 Benefit: 100% = \$100.10</p>
<p>‡ 697</p>	<p>Professional attendance AT A PLACE OTHER THAN CONSULTING ROOMS, by a medical practitioner (other than a general practitioner) on not more than 1 patient on the 1 occasion – each attendance <i>between 11pm and 7am</i>, if:</p> <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and b) the patient's medical condition requires urgent treatment <p>(See para A.10 of explanatory notes to this Category) Fee: \$118.70 Benefit: 75% = \$89.05 100% = \$118.70</p>
<p>‡ 698</p>	<p>Professional attendance AT CONSULTING ROOMS, by a medical practitioner (other than a general practitioner) on not more than 1 patient on the 1 occasion – each attendance <i>between 11pm and 7am</i>, if:</p> <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and b) the patient's medical condition requires urgent treatment; and c) it is necessary for the practitioner to return to, and specially open, consulting rooms for the attendance <p>(See para A.10 of explanatory notes to this Category) Fee: \$118.70 Benefit: 100% = \$118.70</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: \$77.25 Benefit: 75% = \$57.95 85% = \$65.70</p>
105	<p>Each attendance SUBSEQUENT to the first in a single course of treatment Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00</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: \$64.15 Benefit: 75% = \$48.15 85% = \$54.55</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: \$113.35 Benefit: 75% = \$85.05 85% = \$96.35</p>
108	<p>Each attendance SUBSEQUENT to the first in a single course of treatment Fee: \$71.70 Benefit: 75% = \$53.80 85% = \$60.95</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: \$116.05 Benefit: 75% = \$87.05 85% = \$98.65</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: \$136.30	Benefit: 75% = \$102.25	85% = \$115.90
116	- Each attendance (other than a service to which item 119 applies) SUBSEQUENT to the first in a single course of treatment Fee: \$68.20	Benefit: 75% = \$51.15	85% = \$58.00
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: \$38.80	Benefit: 75% = \$29.10	85% = \$33.00
	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: \$165.40	Benefit: 75% = \$124.05	85% = \$140.60
128	- Each attendance (other than a service to which item 131 applies) SUBSEQUENT to the first in a single course of treatment Fee: \$100.00	Benefit: 75% = \$75.00	85% = \$85.00
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: \$72.00	Benefit: 75% = \$54.00	85% = \$61.20
	CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY) REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN - SURGERY OR HOSPITAL Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where the patient is referred by a medical practitioner, and where <ul style="list-style-type: none"> a) assessment is undertaken that covers: <ul style="list-style-type: none"> - a comprehensive history, including psychosocial history and medication review; - comprehensive multi or detailed single organ system assessment; - the formulation of differential diagnoses; and b) a consultant physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves: <ul style="list-style-type: none"> - an opinion on diagnosis and risk assessment - treatment options and decisions - medication recommendations Not being an attendance on a patient in respect of whom, an attendance under items 110, 116 and 119 has been received on the same day by the same consultant physician. Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same consultant physician. <i>(See para A.12 of explanatory notes to this Category)</i>		
† 132	Fee: \$238.30	Benefit: 75% = \$178.75	85% = \$202.60

CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY) REVIEW OF REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN - SURGERY OR HOSPITAL

Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where

a) a review is undertaken that covers:

- review of initial presenting problem/s and results of diagnostic investigations
- review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment,
- review of original and differential diagnoses; and

b) a modified consultant physician treatment and management plan is provided to the referring practitioner that involves, where appropriate:

- a revised opinion on the diagnosis and risk assessment
- treatment options and decisions
- revised medication recommendations

Not being an attendance on a patient in respect of whom, an attendance under item 110, 116 and 119 has been received on the same day by the same consultant physician.

Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 132 by the same consultant physician, payable no more than twice in any 12 month period.

(See para A.12 of explanatory notes to this Category)

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133

Fee: \$119.30

Benefit: 75% = \$89.50

85% = \$101.45

CONSULT PHYSICIAN/SPECIALIST	CONSULT PHYSICIAN/SPECIALIST
GROUP A28 - GERIATRIC MEDICINE	
† 141	<p>CONSULTANT PHYSICIAN OR SPECIALIST IN GERIATRIC MEDICINE, REFERRED PATIENT, INITIAL COMPREHENSIVE ASSESSMENT AND MANAGEMENT – SURGERY OR HOSPITAL</p> <p>Professional attendance at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, where the patient is at least 65 years old and referred 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 the medical practitioner for the provision of a comprehensive assessment and management plan.</p> <p>An attendance of more than 60 minutes at consulting rooms or hospital during which:</p> <ol style="list-style-type: none"> a) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail, utilising appropriately validated assessment tools where indicated ('assessment'), b) the patient's various health problems and care needs are identified and prioritised ('formulation'), c) a detailed management plan is developed ('management plan'), d) the management plan is explained and discussed with the patient and/or their family and carer(s) where appropriate, and e) the management plan is communicated in writing to the referring medical practitioner. <p>The management plan should include:</p> <ul style="list-style-type: none"> – the prioritised list of health problems and care needs, – short and longer term management goals, – recommended actions or intervention strategies to be undertaken by the patient's general practitioner or other relevant health care providers that are: <ul style="list-style-type: none"> – likely to improve or maintain health status, – readily available, and – acceptable to the patient, their family and carer(s). <p>Not being an attendance on a patient in respect of whom, an attendance under items 104, 105, 107, 108, 110, 116 and 119 has been received on the same day by the same practitioner.</p> <p>Not being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under this item or item 145 by the same practitioner.</p> <p><i>(See para A.13 of explanatory notes to this Category)</i></p> <p>Fee: \$408.80 Benefit: 75% = \$306.60 85% = \$347.50</p>
† 143	<p>CONSULTANT PHYSICIAN OR SPECIALIST IN GERIATRIC MEDICINE, REVIEW OF REFERRED PATIENT, INITIAL COMPREHENSIVE ASSESSMENT AND MANAGEMENT – SURGERY OR HOSPITAL</p> <p>Professional attendance at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist in geriatric medicine and claimed under item 141 or 145, where the review is initiated by the referring medical practitioner practising in general practice.</p> <p>An attendance of more than 30 minutes duration at consulting rooms or hospital where that attendance follows item 141 or 145 and during which:</p> <ol style="list-style-type: none"> a) the patient's health status is reassessed, b) a management plan provided under items 141 or 145 is reviewed and revised, c) the revised management plan is explained to the patient and/or their family and carer(s) and communicated in writing to the referring medical practitioner. <p>Not being an attendance on a patient in respect of whom, an attendance under items 104, 105, 107, 108, 110, 116 and 119 has been received on the same day by the same practitioner.</p> <p>Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under items 141 or 145 by the same practitioner, payable no more than once in any 12 month period, except for where there has been a significant change in the patient's clinical condition or care circumstances that requires a further review.</p> <p><i>(See para A.13 of explanatory notes to this Category)</i></p> <p>Fee: \$255.50 Benefit: 75% = \$191.65 85% = \$217.20</p>

CONSULTANT PHYSICIAN OR SPECIALIST IN GERIATRIC MEDICINE, REFERRED PATIENT, INITIAL COMPREHENSIVE ASSESSMENT AND MANAGEMENT – HOME VISITS

Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, where the patient is at least 65 years old and has been referred 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 the medical practitioner for the provision of a comprehensive assessment and management plan.

An attendance of more than 60 minutes at a place other than consulting rooms or hospital during which:

- a) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail, utilising appropriately validated assessment tools where indicated ('assessment'),
- b) the patient's various health problems and care needs are identified and prioritised ('formulation'),
- c) a detailed management plan is developed ('management plan'),
- d) the management plan is explained and discussed with the patient and/or their family and carer(s) where appropriate,
- e) the management plan is communicated in writing to the referring medical practitioner.

The management plan should include:

- the prioritised list of health problems and care needs,
- short and longer term management goals,
- recommended actions or intervention strategies to be undertaken by the patient's general practitioner or other relevant health care providers that are:
 - likely to improve or maintain health status
 - readily available
 - acceptable to the patient, their family and carer(s)

Not being an attendance on a patient in respect of whom, an attendance under items 104, 105, 107, 108, 110, 116 and 119 has been received on the same day by the same practitioner.

Not being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under this item or 141 by the same practitioner.

(See para A.13 of explanatory notes to this Category)

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145

Fee: \$495.65 **Benefit:** 85% = \$430.45

CONSULTANT PHYSICIAN OR SPECIALIST IN GERIATRIC MEDICINE, REVIEW OF REFERRED PATIENT, INITIAL COMPREHENSIVE ASSESSMENT AND MANAGEMENT – HOME VISITS

Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist in geriatric medicine and claimed under items 141 or 145, where the review is initiated by the referring medical practitioner practising in general practice.

An attendance of more than 30 minutes duration at a place other than consulting rooms or hospital where that attendance follows items 141 or 145 and during which:

- a) the patient's health status is reassessed,
- b) a management plan provided under items 141 or 145 is reviewed and revised,
- c) the revised management plan is explained to the patient and/or their family and carer(s) and communicated in writing to the referring medical practitioner.

Not being an attendance on a patient in respect of whom, an attendance under items 104, 105, 107, 108, 110, 116 and 119 has been received on the same day by the same practitioner.

Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under items 141 or 145 by the same practitioner, payable no more than once in any 12 month period, except for where there has been a significant change in the patient's clinical condition or care circumstances that requires a further review.

(See para A.13 of explanatory notes to this Category)

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147

Fee: \$309.80 **Benefit:** 85% = \$263.35

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.14 of explanatory notes to this Category)

160 **Fee:** \$196.10 **Benefit:** 75% = \$147.10 100% = \$196.10

- For a period of not less than 2 hours but less than 3 hours

(See para A.14 of explanatory notes to this Category)

161 **Fee:** \$326.85 **Benefit:** 75% = \$245.15 100% = \$326.85

- For a period of not less than 3 hours but less than 4 hours

(See para A.14 of explanatory notes to this Category)

162 **Fee:** \$457.45 **Benefit:** 75% = \$343.10 100% = \$457.45

- For a period of not less than 4 hours but less than 5 hours

(See para A.14 of explanatory notes to this Category)

163 **Fee:** \$588.30 **Benefit:** 75% = \$441.25 100% = \$588.30

- For a period of 5 hours or more

(See para A.14 of explanatory notes to this Category)

164 **Fee:** \$653.70 **Benefit:** 75% = \$490.30 100% = \$653.70

GROUP THERAPY

GROUP THERAPY

GROUP A6 - GROUP THERAPY

FAMILY GROUP THERAPY

(Professional attendance for the purpose of group therapy of not less than 1 hours duration given under the direct continuous supervision of a medical practitioner, other than a consultant physician in the practice of his or her specialty of psychiatry, involving members of a family and persons with close personal relationships with that family)

- each group of 2 patients

(See para A.15 of explanatory notes to this Category)

170 **Fee:** \$104.10 **Benefit:** 75% = \$78.10 100% = \$104.10

- each group of 3 patients

(See para A.15 of explanatory notes to this Category)

171 **Fee:** \$109.65 **Benefit:** 75% = \$82.25 100% = \$109.65

- each group of 4 or more patients

(See para A.15 of explanatory notes to this Category)

172 **Fee:** \$133.45 **Benefit:** 75% = \$100.10 100% = \$133.45

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.16 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> <ul style="list-style-type: none"> (i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; OR (ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies <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.16 of explanatory notes to this Category)</p> <p>Fee: \$32.80 Benefit: 100% = \$32.80</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> <ul style="list-style-type: none"> (i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; OR (ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies <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.16 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 193, plus \$22.95 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 \$1.70 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> <ul style="list-style-type: none"> (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>OR</p> <ul style="list-style-type: none"> (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>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.16 of explanatory notes to this Category)</p> <p>Fee: \$62.30 Benefit: 100% = \$62.30</p>

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.16 of explanatory notes to this Category)

CONSULTANT PSYCHIATRIST	CONSULTANT PSYCHIATRIST
	GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
291	<p 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.17 of explanatory notes to this Category)</p> <p>Fee: \$408.80 Benefit: 85% = \$347.50</p>
‡ 293	<p 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, and no payment has been made under item 359, payable no more than once in any 12 month period. (See para A.17 of explanatory notes to this Category)</p> <p>Fee: \$255.50 Benefit: 85% = \$217.20</p>
‡ 296	<p 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 358 or 361 to 370 in the preceding 24 month period (See para A.17 of explanatory notes to this Category)</p> <p>Fee: \$235.05 Benefit: 75% = \$176.30 85% = \$199.80</p>

CONSULTANT PSYCHIATRIST		CONSULTANT PSYCHIATRIST	
‡ 316	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year.	Fee: \$83.10	Benefit: 75% = \$62.35 85% = \$70.65
‡ 318	- 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 358 or 361 to 370 apply exceed 50 attendances in a calendar year.	Fee: \$96.30	Benefit: 75% = \$72.25 85% = \$81.90
‡ 319	- An attendance of more than 45 minutes duration at consulting rooms, where the patient has: (i) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (ii) for persons 18 years and over, been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply do not exceed 160 attendances in a calendar year. <i>(See para A.18 of explanatory notes to this Category)</i>	Fee: \$165.90	Benefit: 75% = \$124.45 85% = \$141.05
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: \$39.15	Benefit: 75% = \$29.40 85% = \$33.30
322	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at hospital	Fee: \$78.10	Benefit: 75% = \$58.60 85% = \$66.40
324	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at hospital	Fee: \$120.20	Benefit: 75% = \$90.15 85% = \$102.20
326	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at hospital	Fee: \$165.90	Benefit: 75% = \$124.45 85% = \$141.05
328	- An attendance of more than 75 minutes duration at hospital	Fee: \$192.45	Benefit: 75% = \$144.35 85% = \$163.60
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: \$71.80	Benefit: 75% = \$53.85 85% = \$61.05
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: \$112.60	Benefit: 75% = \$84.45 85% = \$95.75
334	- An attendance of more than 30 minutes duration but not more than 45 minutes duration where that attendance is at a place other than consulting rooms or hospital	Fee: \$164.05	Benefit: 75% = \$123.05 85% = \$139.45
336	- An attendance of more than 45 minutes duration but not more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital	Fee: \$198.45	Benefit: 75% = \$148.85 85% = \$168.70
338	- An attendance of more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital	Fee: \$225.35	Benefit: 75% = \$169.05 85% = \$191.55

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: \$44.55	Benefit: 75% = \$33.45 85% = \$37.90
344	- FAMILY GROUP PSYCHOTHERAPY on a group of 3 patients, EACH PATIENT Fee: \$59.15	Benefit: 75% = \$44.40 85% = \$50.30
346	- FAMILY GROUP PSYCHOTHERAPY on a group of 2 patients, EACH PATIENT Fee: \$87.45	Benefit: 75% = \$65.60 85% = \$74.35
	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.19 of explanatory notes to this Category)</i>	
348	Fee: \$114.45	Benefit: 75% = \$85.85 85% = \$97.30
350	- An attendance of not less than 45 minutes duration <i>(See para A.19 of explanatory notes to this Category)</i> Fee: \$158.05	Benefit: 75% = \$118.55 85% = \$134.35
	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.19 of explanatory notes to this Category)</i>	
352	Fee: \$114.45	Benefit: 75% = \$85.85 85% = \$97.30
	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 291 to 319 apply), where: -the patient is referred to him or her by a medical practitioner for assessment, diagnosis and/or treatment and is located in a regional, rural or remote area (RRMA3-7), -that consultation and any other consultation to which items 353 to 361 apply, have not exceeded 12 consultations in a calendar year, -any other attendance to which items 300 to 308 and 353 to 358 or 361 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.43 of explanatory notes to this Category)</i>	
+ 353	Fee: \$51.70	Benefit: 75% = \$38.80 85% = \$43.95
+ 355	A telepsychiatry consultation of more than 15 minutes duration but not more than 30 minutes duration. <i>(See para A.43 of explanatory notes to this Category)</i> Fee: \$103.30	Benefit: 75% = \$77.50 85% = \$87.85
+ 356	A telepsychiatry consultation of more than 30 minutes duration but not more than 45 minutes duration. <i>(See para A.43 of explanatory notes to this Category)</i> Fee: \$151.50	Benefit: 75% = \$113.65 85% = \$128.80
+ 357	A telepsychiatry consultation of more than 45 minutes duration but not more than 75 minutes duration <i>(See para A.43 of explanatory notes to this Category)</i> Fee: \$209.05	Benefit: 75% = \$156.80 85% = \$177.70

CONSULTANT PSYCHIATRIST		CONSULTANT PSYCHIATRIST	
+ 358	A telepsychiatry consultation of more than 75 minutes duration (See para A.43 of explanatory notes to this Category) Fee: \$254.65 Benefit: 75% = \$191.00 85% = \$216.50		
	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION VIA TELEPSYCHIATRY FOR REVIEW OF REFERRED PATIENT ASSESSMENT AND MANAGEMENT		
	A telepsychiatry consultation of more than 30 minutes but not more than 45 minutes duration by a consultant physician in the practice of his or her specialty of PSYCHIATRY where: <ul style="list-style-type: none"> a) the patient is located in a regional, rural or remote area (RRMA 3-7) b) in the preceding 12 months, payment has been made under item 291 c) an outcome tool is used where clinically appropriate d) a mental state examination is conducted e) a psychiatric diagnosis is made f) a management plan provided under Item 291 is reviewed and revised g) the reviewed management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement) h) the reviewed management plan is communicated in writing to the referring medical practitioner <p>Not being an attendance on a patient in respect of whom payment has been made under this item or item 293 in the preceding 12 month period.</p>		
† 359	(See para A.43 of explanatory notes to this Category) Fee: \$293.85 Benefit: 75% = \$220.40 85% = \$249.80		
	CONSULTANT PSYCHIATRIST, REFERRED INITIAL CONSULTATION VIA TELEPSYCHIATRY ON A NEW PATIENT		
	A telepsychiatry consultation of more than 45 minutes by a consultant physician in the practice of his or her specialty of PSYCHIATRY where: <ul style="list-style-type: none"> a) the patient is a new patient for this consultant psychiatrist, or a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months b) the patient is located in a regional, rural or remote area (RRMA3-7) <p>Not being an attendance on a patient in respect of whom payment has been made under this item, items 296 to 299, or any of items 300 to 346 or 353 to 370 in the preceding 24 month period.</p>		
† 361	(See para A.43 of explanatory notes to this Category) Fee: \$270.30 Benefit: 75% = \$202.75 85% = \$229.80		
	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND TREATMENT FOLLOWING TELEPSYCHIATRY		
	Professional attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, where: <ul style="list-style-type: none"> - the patient is referred to him or her by a medical practitioner, - that attendance occurs following a telepsychiatry consultation (items 353 to 361), - that attendance and any other attendance to which items 300 to 308 and 353 to 358 or 361 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. <p>These items may only be used after telepsychiatry consultation(s) have been conducted in accordance with items 353 to 361.</p> <p>A face-to-face attendance of not more than 15 minutes duration.</p>		
‡ 364	(See para A.43 of explanatory notes to this Category) Fee: \$39.15 Benefit: 75% = \$29.40 85% = \$33.30		
	A face-to-face attendance of more than 15 minutes duration but not more than 30 minutes duration (See para A.43 of explanatory notes to this Category) Fee: \$78.10 Benefit: 75% = \$58.60 85% = \$66.40		
+ 367	A face-to-face attendance of more than 30 minutes duration but not more than 45 minutes duration. (See para A.43 of explanatory notes to this Category) Fee: \$120.20 Benefit: 75% = \$90.15 85% = \$102.20		
+ 369	A face-to-face attendance of more than 45 minutes duration but not more than 75 minutes duration (See para A.43 of explanatory notes to this Category) Fee: \$165.95 Benefit: 75% = \$124.50 85% = \$141.10		
	A face-to-face attendance of more than 75 minutes duration. (See para A.43 of explanatory notes to this Category) Fee: \$192.45 Benefit: 75% = \$144.35 85% = \$163.60		
370			

CONSULT OCCUPATIONAL PHYSICIAN		CONSULT OCCUPATIONAL PHYSICIAN	
GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES			
	CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - SURGERY OR HOSPITAL (Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner)		
385	-INITIAL attendance in a single course of treatment <i>(See para A.20 of explanatory notes to this Category)</i> Fee: \$77.25	Benefit: 75% = \$57.95	85% = \$65.70
386	- Each attendance SUBSEQUENT to the first in a single course of treatment <i>(See para A.20 of explanatory notes to this Category)</i> Fee: \$38.80	Benefit: 75% = \$29.10	85% = \$33.00
	CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - HOME VISITS (Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner)		
387	- INITIAL attendance in a single course of treatment <i>(See para A.20 of explanatory notes to this Category)</i> Fee: \$113.35	Benefit: 75% = \$85.05	85% = \$96.35
388	- Each attendance SUBSEQUENT to the first in a single course of treatment <i>(See para A.20 of explanatory notes to this Category)</i> Fee: \$71.70	Benefit: 75% = \$53.80	85% = \$60.95

PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
PUBLIC HEALTH PHYSICIAN ATTENDANCES - SURGERY	
	(Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)
410	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management (See para A.33 of explanatory notes to this Category) Fee: \$17.65 Benefit: 75% = \$13.25 85% = \$15.05
411	- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR an attendance of less than 20 minutes duration involving components of a service to which item 412 applies (See para A.33 of explanatory notes to this Category) Fee: \$38.60 Benefit: 75% = \$28.95 85% = \$32.85
412	- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 413 applies (See para A.33 of explanatory notes to this Category) Fee: \$73.25 Benefit: 75% = \$54.95 85% = \$62.30
413	- Attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR an attendance of at least 40 minutes duration for implementation of a management plan (See para A.33 of explanatory notes to this Category) Fee: \$107.85 Benefit: 75% = \$80.90 85% = \$91.70
PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS	
	(Professional attendance at other than consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)
+ 414	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management (See para A.33 of explanatory notes to this Category) Derived Fee: The fee for item 410, plus \$22.95 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 \$1.70 per patient.
+ 415	- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR an attendance of less than 20 minutes duration involving components of a service to which item 416 applies (See para A.33 of explanatory notes to this Category) Derived Fee: The fee for item 411, plus \$22.95 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 \$1.70 per patient.
+ 416	- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 417 applies (See para A.33 of explanatory notes to this Category) Derived Fee: The fee for item 412, plus \$22.95 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 \$1.70 per patient.
+ 417	- Attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR an attendance of at least 40 minutes duration for implementation of a management plan (See para A.33 of explanatory notes to this Category) Derived Fee: The fee for item 413, plus \$22.95 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 \$1.70 per patient.

ATTENDANCES		MEDICAL PRACTITIONER - SPORTS	
GROUP A16 - MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES			
SUBGROUP 1 - SURGERY CONSULTATIONS			
MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES - SURGERY			
LEVEL 1			
	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine		
	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management (See para A.35 of explanatory notes to this Category)		
444	Fee: \$17.65	Benefit: 75% = \$13.25	85% = \$15.05
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.35 of explanatory notes to this Category)		
445	Fee: \$38.60	Benefit: 75% = \$28.95	85% = \$32.85
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.35 of explanatory notes to this Category)		
446	Fee: \$73.25	Benefit: 75% = \$54.95	85% = \$62.30
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.10 of explanatory notes to this Category)		
447	Fee: \$107.85	Benefit: 75% = \$80.90	85% = \$91.70
SUBGROUP 2 - URGENT ATTENDANCES - AFTER HOURS			
MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES – URGENT AFTER-HOURS			
(on not more than 1 patient on the 1 occasion)			
	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 – each attendance (<i>other than an attendance between 11pm and 7am</i>) in an after-hours period, if:		
	c) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and		
	d) the patient's medical condition requires urgent treatment; and		
	it is necessary for the practitioner to return to, and specially open, consulting rooms for the attendanc (See para A.10 of explanatory notes to this Category)		
‡ 448	Fee: \$135.20	Benefit: 75% = \$101.40	85% = \$114.95

ATTENDANCES**MEDICAL PRACTITIONER - SPORTS**

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** – each attendance *between 11pm and 7am* if:

- a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and
- b) the patient's medical condition requires urgent treatment; and
- c) it is necessary for the practitioner to *return to, and specially open, consulting rooms* for the attendance

‡
449 (See para A.10 of explanatory notes to this Category)

Fee: \$159.35

Benefit: 75% = \$119.55

85% = \$135.45

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.44 of explanatory notes to this Category)</i>	
501	Fee: \$30.85	Benefit: 75% = \$23.15 85% = \$26.25
	MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 2	
	Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency medicine physician in the practice of emergency medicine	
	Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems and the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of low complexity. <i>(See para A.44 of explanatory notes to this Category)</i>	
503	Fee: \$52.15	Benefit: 75% = \$39.15 85% = \$44.35
	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.44 of explanatory notes to this Category)</i>	
507	Fee: \$87.70	Benefit: 75% = \$65.80 85% = \$74.55
	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.44 of explanatory notes to this Category)</i>	
511	Fee: \$124.00	Benefit: 75% = \$93.00 85% = \$105.40
	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.44 of explanatory notes to this Category)</i>	
515	Fee: \$192.05	Benefit: 75% = \$144.05 85% = \$163.25

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.45 of explanatory notes to this Category)

519 **Fee:** \$132.00 **Benefit:** 75% = \$99.00 85% = \$112.20

-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.45 of explanatory notes to this Category)

520 **Fee:** \$253.60 **Benefit:** 75% = \$190.20 85% = \$215.60

-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.45 of explanatory notes to this Category)

530 **Fee:** \$415.65 **Benefit:** 75% = \$311.75 85% = \$353.35

-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.45 of explanatory notes to this Category)

532 **Fee:** \$577.70 **Benefit:** 75% = \$433.30 85% = \$512.50

-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.45 of explanatory notes to this Category)

534 **Fee:** \$739.95 **Benefit:** 75% = \$555.00 85% = \$674.75

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

(See para A.45 of explanatory notes to this Category)

536 **Fee:** \$821.00 **Benefit:** 75% = \$615.75 85% = \$755.80

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 (See para A.23 of explanatory notes to this Category) Fee: \$171.15 Benefit: 100% = \$171.15</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 (See para A.23 of explanatory notes to this Category) Fee: \$242.05 Benefit: 100% = \$242.05</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 (See para A.23 of explanatory notes to this Category) Fee: \$171.15 Benefit: 100% = \$171.15</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 (See para A.23 of explanatory notes to this Category) Fee: \$242.05 Benefit: 100% = \$242.05</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 (See para A.24 of explanatory notes to this Category) Fee: \$171.15 Benefit: 100% = \$171.15</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 (See para A.25 of explanatory notes to this Category) Fee: \$204.00 Benefit: 100% = \$204.00</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. (See para A.26 of explanatory notes to this Category) Fee: \$191.80 Benefit: 100% = \$191.80</p>
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.27 of explanatory notes to this Category) Fee: \$204.00 Benefit: 100% = \$204.00</p>

ENHANCED PRIMARY CARE	ENHANCED PRIMARY CARE
+ 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.27 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 714, plus \$22.95 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 \$1.70 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.28 of explanatory notes to this Category)</p> <p>Fee: \$102.20 Benefit: 100% = \$102.20</p>
† 718	<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 with an intellectual disability – 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 719. (See para A.29 of explanatory notes to this Category)</p> <p>Fee: \$204.00 Benefit: 100% = \$204.00</p>
† 719	<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 RESIDENTIAL AGED CARE FACILITY for a health assessment - of a patient with an intellectual disability - not being a health assessment for a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or item 718. (See para A.29 of explanatory notes to this Category)</p> <p>Fee: \$226.95 Benefit: 100% = \$226.95</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			
	<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.30 of explanatory notes to this Category)</p>		
721	Fee: \$127.70	Benefit: 75% = \$95.80	100% = \$127.70
	<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.30 of explanatory notes to this Category)</p>		
723	Fee: \$101.15	Benefit: 75% = \$75.90	100% = \$101.15
	<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.30 of explanatory notes to this Category)</p>		
725	Fee: \$63.85	Benefit: 75% = \$47.90	100% = \$63.85
	<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.30 of explanatory notes to this Category)</p>		
727	Fee: \$63.85	Benefit: 75% = \$47.90	100% = \$63.85
	<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.30 of explanatory notes to this Category)</p>		
+ 729	Fee: \$62.30	Benefit: 100% = \$62.30	

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>(See para A.30 of explanatory notes to this Category)</p> <p>Fee: \$62.30 Benefit: 100% = \$62.30</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 731 applies)</p> <p>(See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$85.60 Benefit: 100% = \$85.60</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 731 applies)</p> <p>(See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$128.40 Benefit: 100% = \$128.40</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 731 applies)</p> <p>(See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$171.15 Benefit: 100% = \$171.15</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 721 to 731 apply)</p> <p>(See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$85.60 Benefit: 100% = \$85.60</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 721 to 731 apply)</p> <p>(See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$128.40 Benefit: 100% = \$128.40</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 721 to 731 apply)</p> <p>(See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$171.15 Benefit: 100% = \$171.15</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 721 to 731 apply) - payable not more than once for each HOSPITAL ADMISSION</p> <p>(See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$85.60 Benefit: 75% = \$64.20 85% = \$72.80</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 721 to 731 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$128.40 Benefit: 75% = \$96.30 85% = \$109.15</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 721 to 731 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$171.15 Benefit: 75% = \$128.40 85% = \$145.50</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 721 to 731 apply) (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 100% = \$61.10</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 721 to 731 apply) (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$97.80 Benefit: 100% = \$97.80</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 721 to 731 apply) (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$134.45 Benefit: 100% = \$134.45</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 721 to 731 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 75% = \$45.85 85% = \$51.95</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 721 to 731 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$97.80 Benefit: 75% = \$73.35 85% = \$83.15</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 721 to 731 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$134.45 Benefit: 75% = \$100.85 85% = \$114.30</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 731 applies) (See para A.32 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 100% = \$61.10</p>

CHRONIC DISEASE MANAGEMENT		CASE CONFERENCES
778	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY , (other than to organise and 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 731 applies) <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$97.80 Benefit: 100% = \$97.80
779	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY , (other than to organise and coordinate the conference), where the conference time is at least 45 minutes, (not being a service associated with a service to which item 731 applies) <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$134.45 Benefit: 100% = \$134.45
CASE CONFERENCE - CONSULTANT PHYSICIAN		
820	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines <i>(See para A.34 of explanatory notes to this Category)</i>	Fee: \$125.60 Benefit: 75% = \$94.20 85% = \$106.80
822	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines <i>(See para A.34 of explanatory notes to this Category)</i>	Fee: \$188.45 Benefit: 75% = \$141.35 85% = \$160.20
823	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines <i>(See para A.34 of explanatory notes to this Category)</i>	Fee: \$251.15 Benefit: 75% = \$188.40 85% = \$213.50
825	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and to coordinate the conference) of 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.34 of explanatory notes to this Category)</i>	Fee: \$90.25 Benefit: 75% = \$67.70 85% = \$76.75
826	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and to coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.34 of explanatory notes to this Category)</i>	Fee: \$143.90 Benefit: 75% = \$107.95 85% = \$122.35
828	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and to coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.34 of explanatory notes to this Category)</i>	Fee: \$197.55 Benefit: 75% = \$148.20 85% = \$167.95
830	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines <i>(See para A.34 of explanatory notes to this Category)</i>	Fee: \$125.60 Benefit: 75% = \$94.20 85% = \$106.80
832	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines <i>(See para A.34 of explanatory notes to this Category)</i>	Fee: \$188.45 Benefit: 75% = \$141.35 85% = \$160.20

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
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 para A.34 of explanatory notes to this Category) Fee: \$251.15 Benefit: 75% = \$188.40 85% = \$213.50</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 para A.34 of explanatory notes to this Category) Fee: \$90.25 Benefit: 75% = \$67.70 85% = \$76.75</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 para A.34 of explanatory notes to this Category) Fee: \$143.90 Benefit: 75% = \$107.95 85% = \$122.35</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 para A.34 of explanatory notes to this Category) Fee: \$197.55 Benefit: 75% = \$148.20 85% = \$167.95</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 (See para A.46 of explanatory notes to this Category) Fee: \$125.60 Benefit: 75% = \$94.20 85% = \$106.80</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 (See para A.46 of explanatory notes to this Category) Fee: \$188.45 Benefit: 75% = \$141.35 85% = \$160.20</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 (See para A.46 of explanatory notes to this Category) Fee: \$251.15 Benefit: 75% = \$188.40 85% = \$213.50</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 (See para A.46 of explanatory notes to this Category) Fee: \$125.60 Benefit: 75% = \$94.20 85% = \$106.80</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 (See para A.46 of explanatory notes to this Category) Fee: \$188.45 Benefit: 75% = \$141.35 85% = \$160.20</p>
866	<p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND 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 (See para A.46 of explanatory notes to this Category) Fee: \$251.15 Benefit: 75% = \$188.40 85% = \$213.50</p>

MULTIDISCIPLINARY CANCER CARE CASE CONFERENCE	
871	<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. (See para A.50 of explanatory notes to this Category)</p> <p>Fee: \$72.55 Benefit: 75% = \$54.45 85% = \$61.70</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. (See para A.50 of explanatory notes to this Category)</p> <p>Fee: \$33.75 Benefit: 75% = \$25.35 85% = \$28.70</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 (See para A.47 of explanatory notes to this Category)</p> <p>Fee: \$43.90 Benefit: 75% = \$32.95</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.36 of explanatory notes to this Category)</p> <p>Fee: \$137.05 Benefit: 100% = \$137.05</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.36 of explanatory notes to this Category)</p> <p>Fee: \$93.85 Benefit: 100% = \$93.85</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) (See para A.37 of explanatory notes to this Category) Fee: \$15.00 Benefit: 100% = \$15.00</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) (See para A.37 of explanatory notes to this Category) Fee: \$32.80 Benefit: 100% = \$32.80</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. (See para A.37 of explanatory notes to this Category) Derived Fee: The fee for item 2501, plus \$22.95 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 \$1.70 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) (See para A.37 of explanatory notes to this Category) Fee: \$62.30 Benefit: 100% = \$62.30</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. (See para A.37 of explanatory notes to this Category) Derived Fee: The fee for item 2504, plus \$22.95 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 \$1.70 per patient.</p>

INCENTIVE ITEMS

GENERAL PRACTITIONER

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.37 of explanatory notes to this Category)
 2507 **Fee:** \$91.70 **Benefit:** 100% = \$91.70

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.37 of explanatory notes to this Category)
 + **Derived Fee:** The fee for item 2507, plus \$22.95 divided by the number of patients seen, up to a maximum of six patients. For
 2509 seven or more patients - the fee for item 2507 plus \$1.70 per patient.

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.38 of explanatory notes to this Category)
 2517 **Fee:** \$32.80 **Benefit:** 100% = \$32.80

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.38 of explanatory notes to this Category)
 + **Derived Fee:** The fee for item 2517, plus \$22.95 divided by the number of patients seen, up to a maximum of six patients. For
 2518 seven or more patients - the fee for item 2517 plus \$1.70 per patient.

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.38 of explanatory notes to this Category) Fee: \$62.30 Benefit: 100% = \$62.30</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.38 of explanatory notes to this Category) Derived Fee: The fee for item 2521, plus \$22.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus \$1.70 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.38 of explanatory notes to this Category) Fee: \$91.70 Benefit: 100% = \$91.70</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.38 of explanatory notes to this Category) Derived Fee: The fee for item 2525, plus \$22.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus \$1.70 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.39 of explanatory notes to this Category) Fee: \$32.80 Benefit: 100% = \$32.80</p>

INCENTIVE ITEMS

GENERAL PRACTITIONER

<p>+ 2547</p>	<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.39 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 2546, plus \$22.95 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 \$1.70 per patient.</p>
<p>2552</p>	<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.39 of explanatory notes to this Category)</p> <p>Fee: \$62.30 Benefit: 100% = \$62.30</p>
<p>+ 2553</p>	<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.39 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 2552, plus \$22.95 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 \$1.70 per patient.</p>
<p>2558</p>	<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.39 of explanatory notes to this Category)</p> <p>Fee: \$91.70 Benefit: 100% = \$91.70</p>
<p>+ 2559</p>	<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.39 of explanatory notes to this Category)</p> <p>Derived Fee: The fee or item 2558, plus \$22.95 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 \$1.70 per patient.</p>

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.37 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.37 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.37 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.37 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.37 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.37 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. (See para A.37 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>																								
	<p 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"> <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. (See para A.38 of explanatory notes to this Category)</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
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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 (See para A.38 of explanatory notes to this Category)</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 (See para A.38 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.39 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.39 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.39 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>

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 former 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.40 of explanatory notes to this Category)</p> <p>Fee: \$153.30 Benefit: 75% = \$115.00 100% = \$153.30</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.40 of explanatory notes to this Category)</p> <p>Fee: \$102.20 Benefit: 75% = \$76.65 100% = \$102.20</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.40 of explanatory notes to this Category)</p> <p>Fee: \$67.45 Benefit: 100% = \$67.45</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 former 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.41 of explanatory notes to this Category)</p> <p>Fee: \$82.10 Benefit: 100% = \$82.10</p>

<p>+ 2723</p>	<p>OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) (See para A.41 of explanatory notes to this Category) Derived Fee: The fee for item 2721, plus \$22.95 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 \$1.70 per patient.</p>
<p>2725</p>	<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) (See para A.41 of explanatory notes to this Category) Fee: \$117.55 Benefit: 100% = \$117.55</p>
<p>+ 2727</p>	<p>OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) (See para A.41 of explanatory notes to this Category) Derived Fee: The fee for item 2725, plus \$22.95 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 \$1.70 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.42 of explanatory notes to this Category)			
2801	Fee: \$136.30	Benefit: 75% = \$102.25	85% = \$115.90
- Each attendance (other than a service to which item 2814 applies) SUBSEQUENT to the first in a single course of treatment (See para A.42 of explanatory notes to this Category)			
2806	Fee: \$68.20	Benefit: 75% = \$51.15	85% = \$58.00
- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment (See para A.42 of explanatory notes to this Category)			
2814	Fee: \$38.80	Benefit: 75% = \$29.10	85% = \$33.00
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.42 of explanatory notes to this Category)			
2824	Fee: \$165.40	Benefit: 85% = \$140.60	
- Each attendance (other than a service to which item 2840 applies) SUBSEQUENT to the first in a single course of treatment (See para A.42 of explanatory notes to this Category)			
2832	Fee: \$100.00	Benefit: 85% = \$85.00	
- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment (See para A.42 of explanatory notes to this Category)			
2840	Fee: \$72.00	Benefit: 85% = \$61.20	
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.42 of explanatory notes to this Category)			
2946	Fee: \$125.60	Benefit: 75% = \$94.20	85% = \$106.80
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.42 of explanatory notes to this Category)			
2949	Fee: \$188.45	Benefit: 75% = \$141.35	85% = \$160.20
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.42 of explanatory notes to this Category)			
2954	Fee: \$251.15	Benefit: 75% = \$188.40	85% = \$213.50
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.42 of explanatory notes to this Category)			
2958	Fee: \$90.25	Benefit: 75% = \$67.70	85% = \$76.75

PAIN AND PALLIATIVE MEDICINE		PALLIATIVE MEDICINE
2972	<p>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.42 of explanatory notes to this Category)</p> <p>Fee: \$143.90 Benefit: 75% = \$107.95 85% = \$122.35</p>	
2974	<p>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.42 of explanatory notes to this Category)</p> <p>Fee: \$197.55 Benefit: 75% = \$148.20 85% = \$167.95</p>	
2978	<p>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.42 of explanatory notes to this Category)</p> <p>Fee: \$125.60 Benefit: 75% = \$94.20 85% = \$106.80</p>	
2984	<p>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.42 of explanatory notes to this Category)</p> <p>Fee: \$188.45 Benefit: 75% = \$141.35 85% = \$160.20</p>	
2988	<p>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.42 of explanatory notes to this Category)</p> <p>Fee: \$251.15 Benefit: 75% = \$188.40 85% = \$213.50</p>	
2992	<p>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.42 of explanatory notes to this Category)</p> <p>Fee: \$90.25 Benefit: 75% = \$67.70 85% = \$76.75</p>	
2996	<p>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.42 of explanatory notes to this Category)</p> <p>Fee: \$143.90 Benefit: 75% = \$107.95 85% = \$122.35</p>	
3000	<p>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.42 of explanatory notes to this Category)</p> <p>Fee: \$197.55 Benefit: 75% = \$148.20 85% = \$167.95</p>	
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.42 of explanatory notes to this Category)		
3005	Fee: \$136.30 Benefit: 75% = \$102.25 85% = \$115.90	
- Each attendance (other than a service to which item 3014 applies) SUBSEQUENT to the first in a single course of treatment (See para A.42 of explanatory notes to this Category)		
3010	Fee: \$68.20 Benefit: 75% = \$51.15 85% = \$58.00	

PAIN AND PALLIATIVE MEDICINE	PALLIATIVE MEDICINE
3014	<p>- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment (See para A.42 of explanatory notes to this Category) Fee: \$38.80 Benefit: 85% = \$33.00</p>
3018	<p>MEDICAL PRACTITIONER (PALLIATIVE MEDICINE SPECIALIST) ATTENDANCE - HOME VISIT</p> <p>Professional attendance at a place other than 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</p> <p>- INITIAL attendance in a single course of treatment (See para A.42 of explanatory notes to this Category) Fee: \$165.40 Benefit: 75% = \$124.05 85% = \$140.60</p>
3023	<p>- Each attendance (other than a service to which item 3028 applies) SUBSEQUENT to the first in a single course of treatment (See para A.42 of explanatory notes to this Category) Fee: \$100.00 Benefit: 85% = \$85.00</p>
3028	<p>- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment (See para A.42 of explanatory notes to this Category) Fee: \$72.00 Benefit: 85% = \$61.20</p>
SUBGROUP 4 - PALLIATIVE MEDICINE CASE CONFERENCES	
3032	<p>CASE CONFERENCES - PALLIATIVE MEDICINE SPECIALIST</p> <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 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.42 of explanatory notes to this Category) Fee: \$125.60 Benefit: 75% = \$94.20 85% = \$106.80</p>
3040	<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 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.42 of explanatory notes to this Category) Fee: \$188.45 Benefit: 75% = \$141.35 85% = \$160.20</p>
3044	<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 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.42 of explanatory notes to this Category) Fee: \$251.15 Benefit: 75% = \$188.40 85% = \$213.50</p>
3051	<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 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.42 of explanatory notes to this Category) Fee: \$90.25 Benefit: 75% = \$67.70 85% = \$76.75</p>
3055	<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 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.42 of explanatory notes to this Category) Fee: \$143.90 Benefit: 75% = \$107.95 85% = \$122.35</p>
3062	<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 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.42 of explanatory notes to this Category) Fee: \$197.55 Benefit: 75% = \$148.20 85% = \$167.95</p>

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.42 of explanatory notes to this Category)</p> <p>Fee: \$125.60 Benefit: 75% = \$94.20 85% = \$106.80</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.42 of explanatory notes to this Category)</p> <p>Fee: \$188.45 Benefit: 75% = \$141.35 85% = \$160.20</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.42 of explanatory notes to this Category)</p> <p>Fee: \$251.15 Benefit: 75% = \$188.40 85% = \$213.50</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.42 of explanatory notes to this Category)</p> <p>Fee: \$90.25 Benefit: 75% = \$67.70 85% = \$76.75</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.42 of explanatory notes to this Category)</p> <p>Fee: \$143.90 Benefit: 75% = \$107.95 85% = \$122.35</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.42 of explanatory notes to this Category)</p> <p>Fee: \$197.55 Benefit: 75% = \$148.20 85% = \$167.95</p>

MEDICAL PRACTITIONER

MEDICAL PRACTITIONER

GROUP A27 - PREGNANCY SUPPORT COUNSELLING

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

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

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.

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 (*see Explanatory note M.8*).

SURGERY CONSULTATION

(professional attendance at consulting rooms)

(*See para A.51 of explanatory notes to this Category*)

4001

Fee: \$67.80

Benefit: 100% = \$67.80

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: \$25.65 Benefit: 100% = \$25.65</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 \$22.95 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 \$1.70 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 \$22.95 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 \$1.70 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 \$41.35 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 \$3.00 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: \$43.45 Benefit: 100% = \$43.45</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 \$22.95 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 \$1.70 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 \$22.95 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 \$1.70 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></p> <p>Derived Fee: The fee for item 5020, plus \$41.35 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 \$3.00 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></p> <p>Fee: \$72.90 Benefit: 100% = \$72.90</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></p> <p>Derived Fee: The fee for item 5040, plus \$22.95 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 \$1.70 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></p> <p>Derived Fee: The fee for item 5040, plus \$22.95 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 \$1.70 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></p> <p>Derived Fee: The fee for item 5040, plus \$41.35 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 \$3.00 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></p> <p>Fee: \$102.35 Benefit: 100% = \$102.35</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></p> <p>Derived Fee: The fee for item 5060, plus \$22.95 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 \$1.70 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></p> <p>Derived Fee: The fee for item 5060, plus \$22.95 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 \$1.70 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></p> <p>Derived Fee: The fee for item 5060, plus \$41.35 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 \$3.00 per patient.</p>

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 \$27.95 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 \$1.25 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 \$31.55 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 \$1.25 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 \$27.95 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 \$1.25 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 \$27.95 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 \$1.25 per patient</p>

ATTENDANCES

ATTENDANCES

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.48 of explanatory notes to this Category)</i> Fee: \$17.65 Benefit: 75% = \$13.25 85% = \$15.05
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.48 of explanatory notes to this Category)</i> Fee: \$38.60 Benefit: 75% = \$28.95 85% = \$32.85
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.48 of explanatory notes to this Category)</i> Fee: \$73.25 Benefit: 75% = \$54.95 85% = \$62.30
5912	Professional attendance of more than 40 minutes duration SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 and A.48 of explanatory notes to this Category)</i> Fee: \$107.85 Benefit: 75% = \$80.90 85% = \$91.70

GROUP A26 - NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
6007	<p>NEUROSURGERY SPECIALIST, REFERRED CONSULTATION, - SURGERY OR HOSPITAL</p> <p>- 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.</p> <p>- Initial attendance in a single course of treatment. (See para A.49 of explanatory notes to this Category)</p> <p>Fee: \$117.05 Benefit: 75% = \$87.80 85% = \$99.50</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> <p>- An attendance of not more than 15 minutes duration. (See para A.49 of explanatory notes to this Category)</p> <p>Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00</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> <p>- An attendance of more than 15 minutes duration but not more than 30 minutes duration. (See para A.49 of explanatory notes to this Category)</p> <p>Fee: \$77.25 Benefit: 75% = \$57.95 85% = \$65.70</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> <p>- An attendance of more than 30 minutes duration but not more than 45 minutes duration. (See para A.49 of explanatory notes to this Category)</p> <p>Fee: \$107.05 Benefit: 75% = \$80.30 85% = \$91.00</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> <p>- An attendance of more than 45 minutes duration. (See para A.49 of explanatory notes to this Category)</p> <p>Fee: \$136.30 Benefit: 75% = \$102.25 85% = \$115.90</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	<p>- patients with myopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye (See para A.21 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>
10802	<p>- patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye (See para A.21 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>
10803	<p>- patients with astigmatism of 3.0 dioptres or greater in 1 eye (See para A.21 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>
10804	<p>- 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.21 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>
10805	<p>- patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para A.21 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>
10806	<p>- 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.21 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>
10807	<p>- 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.21 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>
10808	<p>- patients who, by reason of physical deformity, are unable to wear spectacles (See para A.21 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>
10809	<p>- 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.21 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>
10816	<p>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.22 of explanatory notes to this Category) Fee: \$109.85 Benefit: 75% = \$82.40 85% = \$93.40</p>

OUTLINE OF PROVISIONS FOR MEDICARE BENEFITS FOR OPTOMETRIC SERVICES AND NOTES FOR GUIDANCE

O1. INTRODUCTION

O1.1 All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for services with participating optometrists. The Health Insurance Act contains legislation covering the major elements of the Medicare program.

O1.2 Responsibility for regulating the Medicare program lies with the Australian Government through the Department of Health and Ageing. Medicare Australia is responsible for consideration of applications for the acceptance of optometric undertakings and for the day to day operation of Medicare and the payment of benefits. Addresses of the Department and Medicare Australia (Medicare offices) are located at the end of these Notes.

O2. PARTICIPATION BY OPTOMETRISTS

O2.1 Medicare pays benefits for services provided by optometrists who have signed an agreement to participate in arrangements with the Commonwealth Government. This agreement is formally known as the "Common Form of Undertaking - Participating Optometrists" and is often referred to as the Participating Agreement. A copy of the Undertaking is contained in Section 3 of this book.

O2.2 An optometrist registered or licensed under a law in any State or Territory of Australia, who wishes to become a participating optometrist, is required to sign the Common Form of Undertaking and an employer of optometrists must sign a separate common form of undertaking except where the optometrist and the owner of the business are the same person.

O2.3 Where the optometric practice is conducted in a corporate form, such as a company or partnership, it is necessary for the corporation to become a "participating optometrist", and an additional undertaking must be signed by a person who has authority to give the undertaking on behalf of the organisation.

O2.4 The undertaking sets out the obligations to be met under the arrangements. Copies of the undertaking may be obtained from the Provider Liaison Section, Medicare Australia at the addresses listed at the end of these Notes.

O2.5 Where an employer of optometrists completes an undertaking, that undertaking must identify premises owned by them or in their possession. The relevant details are to be included in schedules 2 and 3 of the undertaking. An undertaking completed by an individual optometrist does not need to identify the premises from which services are to be provided as the Common Form of Undertaking applies to all premises from which the optometrists will provide services.

O2.6 When completed, the undertaking should be returned to the Manager (Eligibility), Medicare Australia, PO Box 1001, Tuggeranong, ACT 2901.

O2.7 The Minister may refuse to accept an undertaking given by an optometrist. In these circumstances the optometrist will be notified in writing of the refusal and is given 30 days to forward a written request to the Minister, to have the matter reviewed.

O2.8 After acceptance by the Minister, or his delegate, of the completed undertaking, a letter of acceptance of the undertaking will be forwarded to the optometrist. At the same time, Medicare Australia will send the optometrist a supply of assignment forms and claim forms for assignment of Medicare benefits, together with the necessary instructions for direct-billing purposes.

O2.9 The Manager (Eligibility) must be notified in writing of any changes to the details furnished by an optometrist in schedule 2 and schedule 3 of the undertaking.

O2.10 Participating optometrists may at any time terminate undertakings either wholly or as they relate to particular premises, by notifying the Manager (Eligibility), Medicare Australia, PO Box 1001, Tuggeranong ACT 2901. The date of termination may not be earlier than 30 days after the date on which the notice is served.

O2.11 The names and addresses of participating optometrists may be obtained from the Manager (Eligibility), Medicare Australia, PO Box 1001, Tuggeranong ACT 2901, if the Minister or the Minister's delegate certifies in writing that this is necessary in the public interest.

O3. PROVIDER NUMBERS

O3.1 To ensure that benefits are paid only for services provided by optometrists registered in a State or Territory of Australia, each optometrist providing services for which a Medicare benefit is payable requires an individual provider number.

O3.2 Provider numbers will be issued only to individual participating optometrists registered in a State or Territory of Australia. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.

O3.3 Provider numbers are allocated to practitioners to enable claims for Medicare benefits to be processed and cheques to be correctly drawn in favour of the practitioner where applicable. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

O3.4 Optometrists can obtain a provider number from Medicare. A separate provider number is issued for each location at which an optometrist practises and has current State/Territory registration. Provider numbers for additional practice locations may also be obtained from Medicare following confirmation of State/Territory registration. Optometrists cannot use another optometrist's provider number.

O3.5 If a practitioner wishes Medicare benefits cheques, which would normally be drawn in favour of the practitioner, to be made payable to another payee and/or another address, written authority can be given to Medicare to do this. This payment to another party is known as a pay group link. There can only be one pay group link for an individual practice location but

multiple practitioners and practice locations can be linked to one pay group. Further information on pay group links may be obtained from Medicare (addresses at the end of the Notes).

Locum Tenens

O3.6 An optometrist who has signed a Common Form of Undertaking and is to provide services at a practice location as a locum for more than 2 weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.

O3.7 If the locum is to provide services at a practice for less than 2 weeks, the locum can use their own provider number or can obtain an additional provider number for that location (see O3.4).

O3.8 Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed a Common Form of Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Undertaking. To ensure benefits are payable when a locum practises in these circumstances, the locum optometrist should:

- Check that they will be providing optometry services on behalf of a participating optometrist ie their employer has a current Common Form of Undertaking
- Notify Medicare Australia in writing, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

O3.9 Locums can direct Medicare payments to a third party eg the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider on direct bill stationery (see para O3.5,7.22).

O4. PATIENT ELIGIBILITY

Eligible persons

O4.1 For the purposes of the optometric arrangements, an eligible person is:

- A person who holds the normal Medicare card as issued to Australian residents; or
- A person who holds a Medicare card which shows "INTERIM CARD" and the period of eligibility; or
- A person who holds a Medicare card which shows "VISITOR RHCA" (Reciprocal Health Care Agreements).

Medicare cards

O4.2 An eligible person who applies to enrol in Medicare (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare Card (green in colour). Cards may be issued for individuals or families.

O4.3 Medicare cards (blue in colour), with the words "INTERIM CARD" are issued in certain circumstances to persons who have applied for permanent resident status.

O4.4 Medicare cards with the words "RECIPROCAL HEALTH CARE " are issued to visitors from countries with which Australia has Reciprocal Health Care Agreements. Visitors from New Zealand and the Republic of Ireland are **NOT** entitled to optometric treatment under RHCA and all other RHCA visitors are only entitled to immediately necessary treatment.

O5. BENEFITS FOR SERVICES BY PARTICIPATING OPTOMETRISTS

What services are covered

O5.1 The services coming within the scope of the optometric benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to consultation on ocular or vision problems or related procedures.

O5.2 Benefits may only be claimed when:

- (a) a service has been performed and a clinical record of the service has been made;
- (b) a significant consultation or examination procedure has been carried out;
- (c) the service has been performed at premises listed in an undertaking;
- (d) the service has involved the personal attendance of both the patient and the optometrist; and
- (e) the service is "clinically relevant" (as defined in the Health Insurance Act) ie a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

Where Medicare benefits are not payable

O5.3 Medicare benefits may not be claimed for attendances for:

- (a) delivery, dispensing, adjustment or repairs of visual aids;
- (b) filling of prescriptions written by other practitioners

O5.4 Benefits are not payable for optometric services associated with:

- (a) cosmetic surgery
- (b) refractive surgery
- (c) tests for fitness to undertake sporting, leisure or vocational activities
- (d) compulsory examinations or tests to obtain any commercial licence (eg flying or driving)
- (e) entrance to schools or other educational facilities
- (f) compulsory examinations for admissions to aged care facilities
- (g) vision screening

O5.5 Medicare benefits are not payable for services in the following circumstances:

- (a) where the expenses for the service are paid or payable to a recognised (public) hospital;
- (b) where the service is provided by teaching institutions to patients of supervised students;
- (c) where the service is not "clinically relevant" (as described in the Health Insurance Act, ie a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered).

O5.6 Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric service where:

- (a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory; or
- (b) the service was rendered in one or more of the following circumstances –
 - (i) the employer arranges or requests the consultation
 - (ii) the results are provided to the employer by the optometrist
 - (iii) the employer requires that the employee have their eyes examined
 - (iv) the account for the consultation is sent to the employer
 - (v) the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's workplace.

Services rendered to an optometrist's dependants, employer or practice partner or dependants

O5.7 A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to his or her employer or practice partner or any dependants of that employer or partner.

6. SCHEDULE FEES AND MEDICARE BENEFITS

Schedule fees and Medicare benefits

O6.1 Optometrists participating in the scheme agree not to charge more than the Schedule fees for services covered by Medicare, and also, that charges for appliances shall not include any amount related to consultation procedures for which benefits are payable. The only exceptions are for Item 10907 and in relation to domiciliary visits - see paragraphs O6.13 and O6.19 – O6.26.

O6.2 The services provided by participating optometrists which attract benefits are set out in the Health Insurance Regulations. Details of the services, including the Schedule fee and Medicare benefits for each service are contained in Section 2 of this book.

O6.3 Medicare benefits are payable at 85% of the Schedule fee for services rendered with a maximum gap payment for any one service of \$61.50 (indexed annually) between the Medicare rebate and the Schedule fee.

O6.4 Where it can be established that payments of \$358.90 (effective from 1 January 2007 and indexed annually from 1 January each year) have been made by a family or an individual during a calendar year regarding the difference between the Medicare benefit and the Schedule fee for out-of-hospital services, benefits will thereafter be paid for the rest of that year up to 100% of the Schedule fee. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

Limiting rule for patient claims

O6.5 Where a fee charged for a service is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances

O6.6 Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the services before they can be regarded as separate attendances.

O6.7 Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (eg 10.30 am and 3.15 pm) in order to assist in the payment of benefits, except where a perimetry item is performed in association with a consultation item where times do not need to be specified.

O6.8 In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Referred comprehensive initial consultations (Item 10905) - Read in conjunction with 09.1 - 09.13

O6.9 For the purposes of Item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

O6.10 Benefits will be paid at the level of Item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist. Referrals from medical practitioners do not attract benefit under item 10905.

O6.11 The optometrist claiming the Item 10905 service is obliged to retain the written referral for a period of twenty-four months.

O6.12 Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation within 24 months of a previous comprehensive consultation (Item 10907)

O6.13 Where a patient receives a comprehensive initial consultation within 24 months of a previous comprehensive consultation provided by another optometrist an additional fee may be charged provided that the service is not direct-billed. The actual additional amount charged is a matter between the optometrist and the patient but it must not exceed an amount equal to the difference between the Schedule fees for Item 10900 and Item 10907.

O6.14 In circumstances where an additional fee is charged the optometrist must inform the patient of the benefit payable for Item 10907 at the time of the consultation and that the additional fee will not attract benefits.

O6.15 Where it is necessary for the optometrist to seek patient information from Medicare in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:-

- (a) the patient is advised of the need to seek the information and the reason the information is required;
- (b) the patient's informed consent to the release of information has been obtained; and
- (c) the patient's records verify the patient's consent to the release of information.

Significant change in visual function requiring comprehensive re-evaluation (Item 10912)

O6.16 Significant changes in visual function which justify the charging of Item 10912 include documented changes of:

- vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)
- visual fields or previously undetected field loss
- binocular vision
- contrast sensitivity or previously undetected contrast sensitivity loss.

New Signs or symptoms/progressive disorder requiring comprehensive re-evaluation (Items 10913 and 10914)

O6.17 When charging Item 10913 and Item 10914, the optometrist must document the new signs or symptoms or the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (Item 10915)

O6.18 Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Domiciliary visits

O6.19 Where patients are unable to travel to an optometrist's practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist travelling to the patient's place of residence, transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

O6.20 Benefits are payable under items 10931 – 10933 to provide some financial assistance in the form of a loading to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The loading is in addition to the consultation item. For the purposes of the loading, acceptable places of residence for domiciliary visits are the patient's home, a residential aged care facility as defined by the *Aged Care Act 1997*, or an institution which means a place (other than a residential aged care facility or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

O6.21 Visits to a hospital are not covered by the new loading, but are covered by the previous arrangements, that is, where a visit to a hospital is provided at the patient's request, an extra fee not exceeding the fee for item 10900 may be charged, in addition to the Schedule fee, providing the service is not bulk-billed. Benefits are not payable in respect of the private charge.

O6.22 Items 10931 – 10933 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the loading is also, and no private charge can then be levied. If the consultation is not bulk-billed, the loading should also not be bulk-billed and a private charge may be levied. The additional private charge must be calculated so that the **total** charges for the basic service, loading and private charge do not exceed an amount which equals twice the fee for item 10900. The usual requirement that the patient must have requested the domiciliary visit applies.

06.23 The choice of appropriate item in the range 10931 - 10933 depends on how many patients are seen at the one location. Benefits are payable under item 10931 where the optometrist travels to see one patient at a single location. Item 10931 can be billed in addition to the consultation item. If the optometrist goes on to see another single patient **at a different location**, that patient can also be billed an item 10931 plus the consultation. However, if two patients are visited at a single location on the same occasion, each of the two patients should be billed item 10932 as well as the consultation item applying to each patient. Similarly, if three patients are visited at a single location on the same occasion, each of the three patients should be billed item 10933 as well as the consultation item applying to each patient.

06.24 Where more than three patients are seen at the same location, additional benefits for domiciliary visits are not payable for the fourth, fifth etc patients. On such occasions, the first three patients should be billed item 10933 as well as the appropriate consultation item, and all subsequent patients may only be billed the appropriate consultation item. Where multiple patients are seen at one location on one occasion, there is no provision for patients to be 'grouped' into twos and threes for billing purposes.

06.25 Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Benefits are not payable in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on accounts issued by optometrists and must not be included in the fees for the service (refer paragraph O7.11).

06.26 Domiciliary visit loading items may not be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941.

Release of prescription

06.27 Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by a person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.

06.28 Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process.

Reminder notices

06.29 The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery

06.30 Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient. The aftercare period includes all post-operative treatment, whether provided by a medical practitioner or an optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

06.31 The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.

06.32 Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and receipt issued to the patient should clearly indicate the fee is non-rebatable.

Computerised Perimetry Services (Items 10940 and 10941)

06.33 Benefit under items 10940 and 10941 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (item 10940) or one eye (item 10941) where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain. Item 10940 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 10941 for unilateral procedures should be claimed, where appropriate.

06.34 These items can be billed either in association with comprehensive consultation items 10900, 10905, 10907, 10912, 10913, 10914 or 10915, or independently, but they cannot be billed with items 10916 or 10918. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed results of the perimetry should be provided to the ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of 2 perimetry services in any 12 month period may be provided.

Low Vision Assessment (Item 10942)

06.35 A benefit is payable under item 10942 where one or more of the tests outlined in the item description are carried out on a patient who has already been established during a comprehensive consultation as having low vision, as specifically defined in the item. This item is not intended for patients expected to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

06.36 Item 10942 may be claimed on the same day as either a comprehensive initial consultation or a subsequent consultation, but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation, or with any of the contact lens items.

Children's vision assessment (Item 10943)

O6.37 Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

O6.38 A benefit is payable under item 10943 where one or more of the assessment and testing procedures outlined in the item description are carried out on a patient aged 3 - 14 years inclusive, and where a finding of significant binocular or accommodative dysfunction is the outcome of the consultation and assessment/testing. The conditions to be assessed under this item are primarily amblyopia and strabismus, but dysfunctions relating to vergences are also covered, providing well established and evidence based optometry practice is observed.

O6.39 A benefit is not payable under item 10943 for the assessment of learning difficulties or learning disabilities.

O6.40 Item 10943 may be claimed on the same day as either a comprehensive consultation or a subsequent consultation, but only where the additional assessment/testing has been carried out on an eligible child. Item 10943 is not intended to be claimed with a brief initial consultation, or with any of the contact lens items.

O7. BILLING PROCEDURES

O7.1 There are three ways benefits may be paid for optometric services:

- (a) the patient may pay the optometrist's account and then claim benefits from a Medicare office by submitting the account and the receipt;
- (b) the patient may submit the unpaid account to Medicare which will then draw a cheque in favour of the optometrist;
or
- (c) the optometrist may bill Medicare instead of the patient for the consultation. This mechanism is known as direct billing. If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Note: Additional charges must not be levied in respect of domiciliary visits and consultations covered by Item 10907 if the services are direct-billed.

Claiming of benefits

O7.2 The patient, upon receipt of an optometrist's account, has two courses open for paying the account and receiving benefits.

Paid accounts

O7.3 If the account has been paid, the claimant can obtain a cash benefit (up to certain limits) from a Medicare office. Alternatively they may lodge a claim by post, by fax in selected pharmacies and Rural Transaction Centres, or telephone (in rural areas throughout Australia) for a payment by Electronic Funds Transfer (EFT) or cheque.

Unpaid accounts

O7.4 Where the patient has not paid the account the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the optometrist.

O7.5 It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist cheques" involving Medicare benefits cannot be sent direct to optometrists, or to patients at an optometrist's address (even if requested by the patient to do so). "Pay optometrist cheques" will be forwarded to the patient's normal address.

O7.6 When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist cheque" the optometrist should indicate on the receipt that a "Medicare" cheque for \$..... was involved in the payment of the account.

Itemised accounts

O7.7 When an optometrist bills a patient for a service, the patient should be issued with a properly itemised account and receipt to enable him/her to claim Medicare benefits. Where both a consultation and computerised perimetry occur, these may be itemised on the same account.

O7.8 Medicare benefits are not payable in respect of an optometric 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 each service to each patient, the following information:-

- (a) patient's name;
- (b) date on which the service(s) was rendered;
- (c) a description of the service(s) (eg "initial consultation, "subsequent consultation" or "contact lens consultation" and/or "computerised perimetry" in those cases where it is performed);
- (d) Medicare Benefits Schedule item number(s);
- (e) the name and practice address or name and provider number of the optometrist who actually rendered the service(s). Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service(s) was given;
- (f) the fee charged for the service(s);
- (g) the time each service began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item, except where a perimetry item is performed in association with a consultation item, where times do not need to be specified.

O7.9 The optometrist billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the optometrist.

O7.10 Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered optometrist practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the optometrist's provider number are included on accounts, receipts and assignment forms.

O7.11 Details of any charges made other than for services, eg a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.

O7.12 Patients must be eligible to receive Medicare benefits and must also meet the clinical requirements outlined in the relevant item descriptors.

Duplicate accounts

O7.13 Only one original itemised account per service should be issued, except in circumstances where both a consultation and computerised perimetry occur, in which case these may be itemised on the same original account. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (direct billing) arrangements

O7.14 Under the Health Insurance Act an Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

O7.15 If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- the patient's Medicare 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.

Use of Medicare cards in direct billing

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

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

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

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

07.20 It is important for the optometrist to check the eligibility of patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement.

Assignment of benefit forms

07.21 Only the approved forms available from Medicare Australia can be used to direct bill patients for optometric services and no other form can be used without its approval.

(a) **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 comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy.

(b) **Form DB4**

This is a continuous stationery version of Form DB2 and has been designed for use on most office accounting machines.

The Claim for Assigned Benefits (Form DB1N, DB1H)

07.22 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.

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

07.24 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.

Time limits applicable to lodgement of claims for Medicare benefits

07.25 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.

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

08. LIMITATIONS ON BENEFITS

Single Course of Attention

08.1 A reference to a single course of attention means:-

(a) In the case of Items 10900 to 10918 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

(b) In relation to Items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses.

Initial consultations

08.2 The initial consultation item (Item 10900) is payable once only within 24 months of the previous standard consultation (Item 10900, 10905, 10907, 10912, 10913, 10914 or 10915). However, a benefit is payable under Item 10912, 10913, 10914 or 10915 where the patient has an ocular condition which necessitates a further course of attention being started within 24 months of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items (see paragraphs 06.16, 06.17 and 06.18).

O8.3 Where an attendance would have been covered by Item 10900,10905, 10907, 10912, 10913, 10914 or 10915 but is of 15 minutes duration or less, Item 10916 (Short consultation) applies.

Second or subsequent consultations (Item 10918)

O8.4 Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by Item 10918.

Contact lens consultations (Items 10921 to 10930)

O8.5 In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in Items 10921 to 10929.

For claims under Items 10921,10922,10923,10925 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

O8.6 Medicare benefits are not payable for Item 10929 in circumstances where patients want contact lenses for:

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

O8.7 All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under Items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. Any visits related to the prescribing and fitting of lenses are regarded to be covered by the relevant item in the range 10921 to 10930. The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses. Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not Items 10921 to 10930).

O8.8 For patients not eligible for Medicare rebates for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item number should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".

O8.9 Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

O8.10 When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.

O8.11 Benefit under Items 10921-10929 is payable once only in any period of 36 consecutive months except where circumstances are met under Item 10930 within a 36 month period.

Additional payments for optometrists visiting isolated areas (the Visiting Optometrists Scheme)

O8.12 Special arrangements exist under the provisions of Section 129A of the Health Insurance Act to enable optometrists who visit isolated areas where optometric services are not otherwise available to provide services without additional charge to patients. Optometrists are particularly encouraged to provide these services to Aboriginal and Torres Strait Islander communities in remote areas.

O8.13 Under these arrangements, assistance may be provided in the form of per capita payments directly related to the numbers of patients attended, with individual rates approved for each applicant who meets the criteria for assistance, in respect of visits to specified locations.

O8.14 This assistance is provided because the participating nature of the benefit arrangements does not permit optometrists to charge fees higher than Medicare Schedule fees to offset the additional costs involved in visiting remote areas.

O8.15 Visiting optometrists may obtain application forms for such assistance from the State Manager, Australian Government Department of Health and Ageing. Addresses of State offices are located at the end of these Notes.

O8.16 Visiting optometrists should also note that Regional Eye Health Coordinators located in several Aboriginal Community Controlled Health Services in each State and Territory may be able to assist in arranging and establishing ongoing visits. Optometrists are advised to contact their State Office of the Australian Government Department of Health and Ageing.

O9. REFERRALS (Read in connection with O6.9 to O6.12)

General

O9.1 Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

O9.2 Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate.

O9.3 Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.

O9.4 A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefit at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the unreferred rate.

O9.5 Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See paragraph O9.15 regarding emergency situations.

What is a referral

O9.6 For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

O9.7 Subject to the exceptions in paragraph O9.8 below, for a valid "referral" to take place:

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

O9.8 The exceptions to the requirements in paragraph O9.7 are that:

- (a) sub-paragraphs (ii) and (iii) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see para O9.15); and
- (b) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid

O9.9 A referral from an optometrist to an ophthalmologist is valid for 12 months unless the optometrist specifies on the referral that the referral is for a different period (eg 3, 6 or 18 months or valid indefinitely).

O9.10 The referral applies for the period specified in the referral from the date that the ophthalmologist provides the first service to the patient. If there is no period specified in the referral then the referral is valid for 12 months from the date of the first service provided by the ophthalmologist.

O9.11 Referrals for longer than 12 months should be made only when the patient's clinical condition requires continuing care and management

O9.12 An optometrist may write a new referral when a patient presents with a condition unrelated to the condition for which the previous referral to an ophthalmologist was written. In these circumstances Medicare benefits for the consultation with the ophthalmologist would be payable at initial consultation rates.

O9.13 A new course of treatment for which Medicare benefits would be payable at the initial consultation rates will also be paid where the referring optometrist:-

- (a) deems it necessary for the patient's condition to be reviewed; and
- (b) the patient is seen by the ophthalmologist outside the currency of the previous referral; and
- (c) the patient was last seen by the specialist ophthalmologist more than 9 months earlier the attendance following a new referral.

Self referral

O9.14 Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Emergency situations

O9.15 Medicare benefits are payable even though there is no written referral in an emergency situation (as defined in the regulations). The specialist or the consultant physician should be of the opinion that the service must be rendered as quickly as possible and endorses the account, receipt or assignment form "Emergency referral".

O9.16 A referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist if attendances subsequent to the emergency attendance are to attract Medicare benefits at the referred rate.

O10. PROVISION FOR REVIEW AND INQUIRY

Optometric Benefits Consultative Committee (OBCC)

O10.1 The OBCC is an advisory committee established in 1990 by arrangement between the Minister and Optometrists Association Australia.

O10.2 The OBCC's functions are:

- (a) to consider the appropriateness of existing Medicare Benefits Schedule items, including the need to combine, delete or create items, and the need to amend item descriptions;
- (b) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;

- (c) to provide a forum for discussion on fees and fee relativities for individual optometric items in the Medicare Benefits Schedule (but not so as to involve a general review of the overall level of optometric fees);
- (d) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the Health Insurance Act and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;
- (e) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

O10.3 The OBCC comprises two representatives from the Department of Health and Ageing, two representatives from Medicare Australia, and three representatives from Optometrists Association Australia.

Professional Services Review (PSR) Scheme

O10.4 The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). A health practitioner is a medical practitioner, a dentist, an optometrist, a chiropractor, physiotherapist or a podiatrist.

O10.5 Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude 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.

O10.6 Medicare Australia monitors health practitioners' claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, Medicare Australia can request that the Director of PSR review the provision of services by the practitioner.

O10.7 From 1 January 2003, changes were introduced to clarify each stage in the PSR process, and to strengthen the procedural fairness provisions available to the person under review.

O10.8 The revised PSR arrangements apply in relation to requests by Medicare Australia to the Director of PSR made after 1 January 2003.

O11 PENALTIES AND LIABILITIES

Penalties

O11.1 Penalties of up to \$10,000 or imprisonment for up to five years may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used in connection with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

O11.2 A penalty of up to \$1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without necessary details having been entered on the form before the patient signs or who fails to give the patient a copy of the completed form.

Medicare Participation Review Committee (MPRC)

O11.3 The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who has been successfully prosecuted for defrauding Medicare.

O11.4 The Committees have a discretionary range of options from taking no action against the practitioner through counselling and reprimand to full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

DOMICILIARY VISITS

An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10932, 10933, 10940 or 10941) applies (the applicable item) if the service is:

- a) rendered at a place other than consulting rooms, being at:
 - (i) a patient's home: or
 - (ii) residential aged care facility: or
 - (iii) an institution; and
- b) performed on **one patient** at a single location on one occasion, and
- c) either:
 - (i) bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item; or
 - (ii) not bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item

(See para O.6 of explanatory notes to this Category)

10931 **Fee:** \$22.35 85% = \$19.00

An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10933, 10940 or 10941) applies (the applicable item) if the service is:

- a) rendered at a place other than consulting rooms, being at:
 - (i) a patient's home: or
 - (ii) residential aged care facility: or
 - (iii) an institution; and
- b) performed on **two patients** at the same location on one occasion, and
- c) either:
 - (i) bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item; or
 - (ii) not bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item

(See para O.6 of explanatory notes to this Category)

10932 **Fee:** \$11.15 85% = \$9.50

An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10932, 10940 or 10941) applies (the applicable item) if the service is:

- a) rendered at a place other than consulting rooms, being at:
 - (i) a patient's home: or
 - (ii) residential aged care facility: or
 - (iii) an institution; and
- b) performed on **three patients** at the same location on one occasion, and
- c) either:
 - (i) bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item; or
 - (ii) not bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item

(See para O.6 of explanatory notes to this Category)

10933 **Fee:** \$7.45 85% = \$6.35

COMPUTERISED PERIMETRY

Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - to a maximum of 2 examinations (including examinations to which item 10941 applies) in any 12 month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies

(See para O.6 of explanatory notes to this Category)

10940 **Fee:** \$61.20 85% = \$52.05

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 (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.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).

Provision of monitoring and support for a person with a chronic disease by a practice nurse or registered Aboriginal Health Worker (item 10997)

M.2.43 Item 10997 may be claimed by a medical practitioner, including a general practitioner but not including a specialist or consultant physician, where a monitoring and support service for a person with a chronic disease care plan is provided by a practice nurse or registered Aboriginal Health Worker on behalf of that medical practitioner.

M.2.44 All GPs whether vocationally registered or not are eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

M.2.45 Item 10997 does not apply for services that are provided by any other Commonwealth or State funded services. 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, item 10997 can be claimed for services provided by practice nurses or registered Aboriginal Health Workers salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

M.2.46 Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP.

M.2.47 Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP reviews of Care Plans.

The services provided by the practice nurse or Aboriginal Health Worker should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

M.2.48 Item 10997 may be claimed up to a maximum of 5 times per patient per calendar year.

M.2.49 Item 10997 may only be accessed by a patient with a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan (items 721, 723, 725, 727, 729, 731).

M.2.50 Patients whose condition is unstable/deteriorating should be referred to their GP for further treatment.

M.2.51 A practice nurse means a registered or enrolled nurse or Nurse Practitioner who is employed by, or whose services are otherwise retained by a general practice.

M.2.52 An Aboriginal Health Worker means a person in the Northern Territory who is registered as an Aboriginal Health Worker 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.2.53 In all cases, the GP under whose supervision the chronic disease monitoring and support is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP must be satisfied that the practice nurse is appropriately qualified and trained to provide chronic disease support and monitoring. GPs are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

M.2.54 General practices where nurses or Aboriginal Health Workers provide chronic disease support and monitoring, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

M.2.55 Continuing professional development is recommended for all nurses and Aboriginal Health Workers providing chronic disease monitoring and support.

M.2.56 Supervision by the GP at a distance is recognised as an acceptable form of supervision. This means that the claiming GP does not have to be physically present at the time the service is provided. However, the GP should be able to be contacted if required.

M.2.57 Where the GP and practice nurse/Aboriginal Health Worker are at the same location, the GP is not required to be present while the chronic disease monitoring and support is undertaken. It is up to the GP to decide whether they need to see the patient. Where the GP has a consultation with the patient, then the GP 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 or Aboriginal Health Worker is itemised separately under item 10997 and should not be counted as part of the Medicare item claimed for time spent with the GP. Where the practice nurse or Aboriginal Health Worker provides another service (eg immunisation) on the same day, the GP is able to claim for both practice nurse/Aboriginal Health Worker items.

M.2.58 Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10997 provided the conditions of item 10990 or 10991 are satisfied (see explanatory note M.1).

M.3 ALLIED HEALTH (ITEMS 10950 TO 10970)

M.3.1 ELIGIBLE PATIENTS

Medicare benefits are available for certain services provided by eligible allied health professionals to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan. The allied health services must be recommended in the patient's EPC plan as part of the management of their chronic condition.

Chronic conditions and complex care needs

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.

EPC plan

Patients are considered to be managed under an EPC plan, if during the last two years:

- their GP has put in place a GP Management Plan (MBS Chronic Disease Management (CDM) item 721) **and** Team Care Arrangements (MBS Chronic Disease Management (CDM) item 723); or
- their GP has reviewed their existing EPC plan and claimed MBS item 725 and 727; or
- their GP has contributed to or reviewed a multidisciplinary care plan prepared for them as a resident of an aged care facility and claimed item 731.

For more information on the CDM EPC planning items, refer to the explanatory notes for these items – Note A.30.

Important note: Before a Medicare rebate can be paid for the allied health service, 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 that claim has been processed.

EPC planning team

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

Group services

In addition to individual services, patients who have type 2 diabetes may also access new MBS items 81100 to 81125 which provide allied health group services – refer M.9.

M.3.2 REFERRAL REQUIREMENTS

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*. 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.

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 or phoning (02) 6289 4297. GPs may modify the referral form to suit their practice needs (for example, relevant software packages) as long as the information 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, any "unused" services received from 1 January in the following year under that referral 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.3.3 ELIGIBLE ALLIED HEALTH SERVICES

Eligible allied health providers

The following groups of allied health professionals are eligible to provide services under Medicare for patients with a chronic condition and complex care needs. Allied health professionals must meet the provider eligibility requirements set out at paragraph M.3.4, and be registered with Medicare Australia.

- Aboriginal Health Workers
- Audiologists
- 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 \$47.85.

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).

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. The allied health professional or the patient can call Medicare Australia on 132 011 to check this information.

Service length and type

Services provided 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 each 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.

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 are the responsibility of the patient. However, 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.

Publicly funded services

Items 10950 to 10970 do not apply for services that are provided by any Commonwealth or State funded services or provided to an admitted patient of a hospital.

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 to 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.3.4 ALLIED HEALTH PROFESSIONAL ELIGIBILITY REQUIREMENTS

The allied health items (10950 to 10970) can only be claimed for services provided by eligible allied health professionals who are registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, allied health professionals must meet the specific eligibility requirements detailed below:

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 in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) by a Registered Training Organisation that meets the training standards set by 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 College of Mental Health Nurses, 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', as in force on 1 November 2006.

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 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 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, without limitation, 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.

Changes to provider details

Allied health providers must notify Medicare Australia in writing of all changes to mailing details to ensure that they continue to receive this book and any updates about Medicare rebateable allied health services.

M.3.5 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/epc. For providers, further information is also available 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

ABORIGINAL HEALTH WORKER SERVICE

Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; and
 - (c) the person is referred to the eligible Aboriginal health worker by the medical practitioner using a referral form that has been issued by the Department 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; and
 - (e) the service is provided to the person individually and in person; and
 - (f) the service is of at least 20 minutes duration; and
 - (g) after the service, the eligible Aboriginal health worker gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
 - (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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)

‡
+
10950

Fee: \$56.25 **Benefit:** 85% = \$47.85

DIABETES EDUCATION SERVICE

Diabetes education health service provided to a person by an eligible diabetes educator if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; and
 - (c) the person is referred to the eligible diabetes educator by the medical practitioner using a referral form that has been issued by the Department 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; and
 - (e) the service is provided to the person individually and in person; and
 - (f) the service is of at least 20 minutes duration; and
 - (g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
 - (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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)

‡
+
10951

Fee: \$56.25 **Benefit:** 85% = \$47.85

AUDIOLOGY

Audiology health service provided to a person by an eligible audiologist if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; 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 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; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 20 minutes duration; and
- (g) after the service, the eligible audiologist gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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

‡
+

10952

Fee: \$56.25 **Benefit:** 85% = \$47.85

EXERCISE PHYSIOLOGY

Exercise physiology service provided to a person by an eligible exercise physiologist if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; 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 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; 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):
 - (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 expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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

‡
+

10953

Fee: \$56.25 **Benefit:** 85% = \$47.85

DIETETICS SERVICES

Dietetics health service provided to a person by an eligible dietitian if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; 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 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; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 20 minutes duration; and
- (g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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

‡
+

10954

Fee: \$56.25 **Benefit:** 85% = \$47.85

MENTAL HEALTH SERVICE

Mental health service provided to a person by an eligible mental health worker if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; 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 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; and
 - (e) the service is provided to the person individually and in person; and
 - (f) the service is of at least 20 minutes duration; and
 - (g) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
 - (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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)

‡
+
10956

Fee: \$56.25 **Benefit:** 85% = \$47.85

OCCUPATIONAL THERAPY

Occupational therapy health service provided to a person by an eligible occupational therapist if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; 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 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; and
 - (e) the service is provided to the person individually and in person; and
 - (f) the service is of at least 20 minutes duration; and
 - (g) after the service, the eligible occupational therapist gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
 - (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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)

‡
+
10958

Fee: \$56.25 **Benefit:** 85% = \$47.85

PHYSIOTHERAPY

Physiotherapy health service provided to a person by an eligible physiotherapist if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; 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 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; and
 - (e) the service is provided to the person individually and in person; and
 - (f) the service is of at least 20 minutes duration; and
 - (g) after the service, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
 - (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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)

‡
+
10960

Fee: \$56.25 **Benefit:** 85% = \$47.85

PODIATRY

Podiatry health service provided to a person by an eligible podiatrist if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; and
 - (c) the person is referred to the eligible podiatrist by the medical practitioner using a referral form that has been issued by the Department 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; 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 podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
 - (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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)

‡
+
10962

Fee: \$56.25 **Benefit:** 85% = \$47.85

CHIROPRACTIC SERVICE

Chiropractic health service provided to a person by an eligible chiropractor if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; 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 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; 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 expect to be informed of - in relation to those matters; and
 - (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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)

‡
+
10964

Fee: \$56.25 **Benefit:** 85% = \$47.85

OSTEOPATHY

Osteopathy health service provided to a person by an eligible osteopath if:

- (a) the service is provided to a person who has a chronic condition and complex care needs 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 condition and complex care needs; 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 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; and
 - (e) the service is provided to the person individually and in person; and
 - (f) the service is of at least 20 minutes duration; and
 - (g) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
 - (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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)

‡
+
10966

Fee: \$56.25 **Benefit:** 85% = \$47.85

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 condition 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 condition and complex care needs; 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 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; and (e) after the assessment, the eligible dental practitioner gives a written report to the referring medical practitioner; and (f) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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</p> <p><i>(See para M.4 of explanatory notes to this Category)</i></p> <p>Fee: \$93.70 Benefit: 85% = \$79.65</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 condition 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 condition and complex care needs; 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 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; and (f) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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</p> <p><i>(See para M.4 of explanatory notes to this Category)</i></p> <p>Fee: \$93.70 Benefit: 85% = \$79.65</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 condition 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 condition and complex care needs; 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 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; 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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for 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</p> <p><i>(See para M.4 of explanatory notes to this Category)</i></p> <p>Fee: \$93.70 Benefit: 85% = \$79.65</p>

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.</p> <p><i>(See para M.5 of explanatory notes to this Category)</i></p> <p>Fee: \$10.85 Benefit: 100% = \$10.85</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.</p> <p><i>(See para M.5 of explanatory notes to this Category)</i></p> <p>Fee: \$10.85 Benefit: 100% = \$10.85</p>

GROUP M1 - MANAGEMENT OF BULK-BILLED SERVICES

‡
10990

A medical service to which an item in this table (other than this item or item 10991) applies if:

- (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; 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 M.1 of explanatory notes to this Category)

Fee: \$6.35 **Benefit:** 85% = \$5.40

‡
10991

A medical service to which an item in this table (other than this item or item 10990) applies if:

- (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; 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 M.1 of explanatory notes to this Category)

Fee: \$9.60 **Benefit:** 85% = \$8.20

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; 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: \$9.60

Benefit: 85% = \$8.20

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.</p> <p><i>(See para M.2 of explanatory notes to this Category)</i></p> <p>Fee: \$10.85 Benefit: 100% = \$10.85</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.</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: \$21.70 Benefit: 100% = \$21.70</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.</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: \$21.70 Benefit: 100% = \$21.70</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.</p> <p><i>(See para M.2 of explanatory notes to this Category)</i></p> <p>Fee: \$10.85 Benefit: 100% = \$10.85</p>
† 10997	<p>Service provided to a person with a chronic disease by a practice nurse or registered Aboriginal Health Worker 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; and</p> <p>(c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and</p> <p>(d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan to a maximum of 5 services per patient in a calendar year</p> <p><i>(See para M.2 of explanatory notes to this Category)</i></p> <p>Fee: \$10.85 Benefit: 100% = \$10.85</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.</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: \$10.85 Benefit: 100% = \$10.85</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.</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: \$10.85 Benefit: 100% = \$10.85</p>

CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

EXPLANATORY NOTES

MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

D1.1 Electronencephalography (EEG), Prolonged Recording (item 11003)

D1.1.1 Extended EEG recording of at least 3 hours duration, other than ambulatory or video recording, including Multiple Sleep Latency Testing (MSLT) is covered under item 11003.

D1.2 Electronencephalography (EEG), Ambulatory or Video, Prolonged Recording (items 11004 and 11005)

D1.2.1 These items cover prolonged ambulatory or video EEG, recording of at least 3 hours duration for:

- Diagnosing the basis of episodic neurological dysfunction;
- Characterising the nature of a patient's epileptic seizures;
- Localising seizures in patients with uncontrolled epilepsy, with a view to surgery; or
- Assessing treatment response where subclinical seizures are suspected.

D1.2.2 For extended ambulatory or video EEG of at least 3 hours but not more than 24 hours duration, item 11004 should be claimed. However, where ambulatory or video 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 Computerised perimetry performed by optometrists is covered by MBS items 10940 and 10941. Items 11221 - 11225 should not be used to repeat perimetry unless clinically necessary (Such as where the results of the perimetry have been provided by the optometrist referring the patient to an ophthalmologist).

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 Item 11240 and 11241 may only be utilised once per patient per practitioner. 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 D1.13.

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 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 12323)

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 The addition of item 12323 from 1 April 2007 will enable the payment of a Medicare benefit for a bone densitometry service performed on a patient aged 70 years or over. The Government has decided to expand access to Medicare subsidised bone mineral density testing to coincide with the expanded eligibility for the osteoporosis medication 'alendronate' under the Pharmaceutical Benefits Scheme.

D1.26.3 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

D1.26.4 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, 12321 and 12323.

D1.26.5 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.

D1.26.6 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.

D1.26.7 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.

D1.26.8 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

D1.26.9 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.

D1.26.10 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.

D1.26.11 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.

D1.26.12 For Items 12315 and 12318

A malabsorptive disorder is defined as one or more of the following:

- (a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or
- (b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level;
or
- (c) histologically proven Coeliac disease.

DIAGNOSTIC	NEUROLOGY
GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	
SUBGROUP 1 - NEUROLOGY	
11000	ELECTROENCEPHALOGRAPHY, not being a service: (a) associated with a service to which item 11003, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.) Fee: \$111.20 Benefit: 75% = \$83.40 85% = \$94.55
11003	ELECTROENCEPHALOGRAPHY, prolonged recording of at least 3 hours duration, not being a service: (a) associated with a service to which item 11000, 11004, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices <i>(See para D1.1 of explanatory notes to this Category)</i> Fee: \$294.20 Benefit: 75% = \$220.65 85% = \$250.10
11004	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices <i>(See para D1.2 of explanatory notes to this Category)</i> Fee: \$294.20 Benefit: 75% = \$220.65 85% = \$250.10
11005	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on each day subsequent to the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11004, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices <i>(See para D1.2 of explanatory notes to this Category)</i> Fee: \$294.20 Benefit: 75% = \$220.65 85% = \$250.10
11006	ELECTROENCEPHALOGRAPHY, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices Fee: \$150.85 Benefit: 75% = \$113.15 85% = \$128.25
11009	ELECTROCORTICOGRAPHY Fee: \$205.65 Benefit: 75% = \$154.25 85% = \$174.85
11012	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies) <i>(See para D1.3 of explanatory notes to this Category)</i> Fee: \$101.10 Benefit: 75% = \$75.85 85% = \$85.95
11015	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies) Fee: \$135.35 Benefit: 75% = \$101.55 85% = \$115.05
11018	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies) Fee: \$202.25 Benefit: 75% = \$151.70 85% = \$171.95
11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations Fee: \$135.35 Benefit: 75% = \$101.55 85% = \$115.05
11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 1 or 2 studies <i>(See para D1.4 and D1.8 of explanatory notes to this Category)</i> Fee: \$102.85 Benefit: 75% = \$77.15 85% = \$87.45
11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 3 or more studies <i>(See para D1.4 and D1.8 of explanatory notes to this Category)</i> Fee: \$152.50 Benefit: 75% = \$114.40 85% = \$129.65

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>, 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:-</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>- each additional examination (See para D1.6 and D1.7 and D1.8 of explanatory notes to this Category)</p> <p>Fee: \$36.90 Benefit: 75% = \$27.70 85% = \$31.40</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: \$110.85 Benefit: 75% = \$83.15 85% = \$94.25</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 II apply</p> <p>Fee: \$73.55 Benefit: 75% = \$55.20 85% = \$62.55</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 II apply (See para D1.9 of explanatory notes to this Category)</p> <p>Fee: \$73.55 Benefit: 75% = \$55.20 85% = \$62.55</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 II apply (See para D1.9 of explanatory notes to this Category)</p> <p>Fee: \$93.60 Benefit: 75% = \$70.20 85% = \$79.60</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 II apply (See para D1.9 of explanatory notes to this Category)</p> <p>Fee: \$72.35 Benefit: 75% = \$54.30 85% = \$61.50</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 II apply (See para D1.9 of explanatory notes to this Category)</p> <p>Fee: \$72.35 Benefit: 75% = \$54.30 85% = \$61.50</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: \$173.80 Benefit: 75% = \$130.35 85% = \$147.75</p>
11303	<p>ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears</p> <p>Fee: \$173.80 Benefit: 75% = \$130.35 85% = \$147.75</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: \$286.20 Benefit: 75% = \$214.65 85% = \$243.30</p>
11306	<p>Nondeterminate AUDIOMETRY (See para D1.12 of explanatory notes to this Category)</p> <p>Fee: \$19.85 Benefit: 75% = \$14.90 85% = \$16.90</p>
11309	<p>AUDIOGRAM, air conduction (See para D1.13 of explanatory notes to this Category)</p> <p>Fee: \$23.75 Benefit: 75% = \$17.85 85% = \$20.20</p>

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: \$125.20 Benefit: 75% = \$93.90 85% = \$106.45</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: \$18.50 Benefit: 75% = \$13.90 85% = \$15.75</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: \$32.20 Benefit: 75% = \$24.15 85% = \$27.40</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: \$55.75 Benefit: 75% = \$41.85 85% = \$47.40</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: \$62.55 Benefit: 75% = \$46.95 85% = \$53.20</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: \$52.10 Benefit: 75% = \$39.10 85% = \$44.30</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: \$68.40 Benefit: 75% = \$51.30 85% = \$58.15</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: \$68.40 Benefit: 75% = \$51.30 85% = \$58.15</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: \$57.55 Benefit: 75% = \$43.20 85% = \$48.95</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: \$57.55 Benefit: 75% = \$43.20 85% = \$48.95</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: \$101.50 Benefit: 75% = \$76.15 85% = \$86.30</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: \$68.40 Benefit: 75% = \$51.30 85% = \$58.15</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: \$68.55 Benefit: 75% = \$51.45 85% = \$58.30</p>
11627	<p>PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age</p> <p>Fee: \$206.50 Benefit: 75% = \$154.90 85% = \$175.55</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: \$28.20 Benefit: 75% = \$21.15 85% = \$24.00</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: \$14.05 Benefit: 75% = \$10.55 85% = \$11.95</p>
11702	<p>TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only</p> <p>Fee: \$14.05 Benefit: 75% = \$10.55 85% = \$11.95</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: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20</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: \$151.25 Benefit: 75% = \$113.45 85% = \$128.60</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: \$46.85 Benefit: 75% = \$35.15 85% = \$39.85</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: \$25.50 Benefit: 75% = \$19.15 85% = \$21.70</p>

DIAGNOSTIC	GASTROENTEROLOGY & COLORECTAL
11712	<p>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</p> <p>Fee: \$137.35 Benefit: 75% = \$103.05 85% = \$116.75</p>
11713	<p>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></p> <p>Fee: \$62.95 Benefit: 75% = \$47.25 85% = \$53.55</p>
11715	<p>BLOOD DYE DILUTION INDICATOR TEST</p> <p>Fee: \$109.10 Benefit: 75% = \$81.85 85% = \$92.75</p>
11718	<p>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</p> <p>Fee: \$31.40 Benefit: 75% = \$23.55 85% = \$26.70</p>
11721	<p>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</p> <p>Fee: \$62.95 Benefit: 75% = \$47.25 85% = \$53.55</p>
11722	<p>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</p> <p>Fee: \$31.40 Benefit: 75% = \$23.55 85% = \$26.70</p>
11724	<p>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</p> <p>Fee: \$152.50 Benefit: 75% = \$114.40 85% = \$129.65</p>
11727	<p>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</p> <p>Fee: \$85.65 Benefit: 75% = \$64.25 85% = \$72.85</p>
SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL	
11800	<p>OESOPHAGEAL MOTILITY TEST, manometric</p> <p>Fee: \$157.60 Benefit: 75% = \$118.20 85% = \$134.00</p>
11810	<p>CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation</p> <p>Fee: \$157.60 Benefit: 75% = \$118.20 85% = \$134.00</p>
11820	<p>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), (not being a service associated with double balloon enteroscopy), if:</p> <p>(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</p> <p>(b) the patient to whom the service is provided:</p> <p style="padding-left: 40px;">(i) is aged 10 years or over; and</p> <p style="padding-left: 40px;">(ii) has recurrent or persistent bleeding; and</p> <p style="padding-left: 40px;">(iii) is anaemic or has active bleeding; and</p> <p>(c) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and</p> <p>(d) the service is performed within 6 months of the upper gastrointestinal endoscopy and colonoscopy</p> <p><i>(See para D1.22 of explanatory notes to this Category)</i></p> <p>Fee: \$1,841.55 Benefit: 75% = \$1,381.20 85% = \$1,776.35</p>
11830	<p>DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex</p> <p>Fee: \$168.65 Benefit: 75% = \$126.50 85% = \$143.40</p>

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: \$72.60 Benefit: 75% = \$54.45 85% = \$61.75</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: \$106.45 Benefit: 75% = \$79.85 85% = \$90.50</p>
SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	
12200	<p>COLLECTION OF SPECIMEN OF SWEAT by iontophoresis</p> <p>Fee: \$33.60 Benefit: 75% = \$25.20 85% = \$28.60</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: \$2,161.00 Benefit: 75% = \$1,620.75 85% = \$2,095.80</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: \$531.05 Benefit: 75% = \$398.30 85% = \$465.85</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> <ul style="list-style-type: none"> a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient <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, and</i> 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: \$531.05 Benefit: 75% = \$398.30 85% = \$465.85</p>
12210	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED 0 - 12 YEARS, WHERE:</p> <ul style="list-style-type: none"> a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. <p>payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. (See para D1.25 of explanatory notes to this Category)</p> <p>Fee: \$633.80 Benefit: 75% = \$475.35 85% = \$568.60</p>
12213	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED BETWEEN 12 AND 18 YEARS, WHERE:</p> <ul style="list-style-type: none"> a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. <p>payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. (See para D1.25 of explanatory notes to this Category)</p> <p>Fee: \$571.00 Benefit: 75% = \$428.25 85% = \$505.80</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: \$633.80 Benefit: 75% = \$475.35 85% = \$568.60</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: \$571.00 Benefit: 75% = \$428.25 85% = \$505.80</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: \$92.45 Benefit: 75% = \$69.35 85% = \$78.60</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: \$92.45 Benefit: 75% = \$69.35 85% = \$78.60</p>

DIAGNOSTIC	OTHER
12312	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions:</p> <ul style="list-style-type: none"> . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; or . female hypogonadism lasting more than 6 months before the age of 45. <p>Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 12 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12315, 12318 or 12321 applies (Ministerial Determination)</p> <p><i>(See para D1.26 of explanatory notes to this Category)</i></p> <p>Fee: \$92.45 Benefit: 75% = \$69.35 85% = \$78.60</p>
12315	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions:</p> <ul style="list-style-type: none"> . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. <p>Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 24 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12318 or 12321 applies (Ministerial Determination)</p> <p><i>(See para D1.26 of explanatory notes to this Category)</i></p> <p>Fee: \$92.45 Benefit: 75% = \$69.35 85% = \$78.60</p>
12318	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using quantitative computerised tomography, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions:</p> <ul style="list-style-type: none"> . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; . female hypogonadism lasting more than 6 months before the age of 45; . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. <p>Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 24 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12321 applies (Ministerial Determination)</p> <p><i>(See para D1.26 of explanatory notes to this Category)</i></p> <p>Fee: \$92.45 Benefit: 75% = \$69.35 85% = \$78.60</p>
12321	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the measurement of bone density 12 months following a significant change in therapy for:</p> <ul style="list-style-type: none"> . established low bone mineral density; or . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma. <p>Measurement of 2 or more sites - 1 service only in a period of 12 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12318 applies (Ministerial Determination).</p> <p><i>(See para D1.26 of explanatory notes to this Category)</i></p> <p>Fee: \$92.45 Benefit: 75% = \$69.35 85% = \$78.60</p>
+ † 12323	<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, for the measurement of bone mineral density, for a person aged 70 years or over.</p> <p>Measurement of 2 or more sites - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination).</p> <p><i>(See para D1.26 of explanatory notes to this Category)</i></p> <p>Fee: \$92.45 Benefit: 75% = \$69.35 85% = \$78.60</p>

NUCLEAR MEDICINE		NUCLEAR MEDICINE	
GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)			
12500	BLOOD VOLUME ESTIMATION Fee: \$195.65	Benefit: 75% = \$146.75	85% = \$166.35
12503	ERYTHROCYTE RADIOACTIVE UPTAKE SURVIVAL TIME TEST OR IRON KINETIC TEST Fee: \$383.60	Benefit: 75% = \$287.70	85% = \$326.10
12506	GASTROINTESTINAL BLOOD LOSS ESTIMATION involving examination of stool specimens Fee: \$273.90	Benefit: 75% = \$205.45	85% = \$232.85
12509	GASTROINTESTINAL PROTEIN LOSS Fee: \$195.65	Benefit: 75% = \$146.75	85% = \$166.35
12512	RADIOACTIVE B12 ABSORPTION TEST 1 isotope Fee: \$94.85	Benefit: 75% = \$71.15	85% = \$80.65
12515	RADIOACTIVE B12 ABSORPTION TEST 2 isotopes Fee: \$207.60	Benefit: 75% = \$155.70	85% = \$176.50
12518	THYROID UPTAKE (using probe) Fee: \$94.85	Benefit: 75% = \$71.15	85% = \$80.65
12521	PERCHLORATE DISCHARGE STUDY Fee: \$114.35	Benefit: 75% = \$85.80	85% = \$97.20
12524	RENAL FUNCTION TEST (without imaging procedure) Fee: \$143.00	Benefit: 75% = \$107.25	85% = \$121.55
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) Fee: \$76.70	Benefit: 75% = \$57.55	85% = \$65.20
12530	WHOLE BODY COUNT not being a service associated with a service to which another item applies Fee: \$114.35	Benefit: 75% = \$85.80	85% = \$97.20
12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled ¹³ CO ₂ or ¹⁴ CO ₂ , for either:- (a) the confirmation of <i>Helicobacter pylori</i> colonisation, OR (b) the monitoring of the success of eradication of <i>Helicobacter pylori</i> . Fee: \$76.40	Benefit: 75% = \$57.30	85% = \$64.95

CATEGORY 3 - THERAPEUTIC PROCEDURES

EXPLANATORY NOTES

MISCELLANEOUS THERAPEUTIC PROCEDURES (Group T1)

T1.1 Hyperbaric Oxygen Therapy (Items 13015, 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.

T1.1.3 Item 13015 provides coverage for hyperbaric oxygen treatment of soft tissue radiation injury and radio necrosis, and hypoxic problem wounds in non-diabetic patients. It is funded on an interim basis and will cease on 31 October 2010.

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 - 13251)

T1.4.1 With the exception of items 37605 and 37606, 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, or any pathology tests. 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, 13251, 37605, 37606 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.

T1.4.9 Item 13251 provides for intracytoplasmic sperm injection for male factor infertility under the following circumstances:

- where fertilisation with standard IVF is highly unlikely to be successful; or
- where in a previous cycle of IVF, the fertilisation rate has failed due to low or no fertilisation.

Item 13251 excludes a service to which item 13218 applies.

Sperm retrieval procedures associated with intracytoplasmic sperm injection are covered under items 37605 and 37606.

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 hemodynamic 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 IMMUNOMODULATING AGENT (Item 14245)

T1.15.1 Item 14245 applies only to a service provided by a medical practitioner who is registered by the Medicare Australia CEO to participate in the arrangements made, under paragraph 100 (1) (b) of the National Health Act 1953, for the purpose of providing an adequate pharmaceutical service for persons requiring treatment with an immunomodulating agent.

T1.15.2 These drugs are associated with risk of anaphylaxis which must be treated by a medical practitioner. For this reason a medical practitioner needs to be available at all times during the infusion in case of an emergency.

RADIATION ONCOLOGY (Group T2)

T2.1 General

T2.1.1 The level of benefits for radiotherapy depends not only on the number of fields irradiated but also on the frequency of irradiation. In the items related to additional fields, it is to be noted that treatment by rotational therapy is considered to be equivalent to the irradiation of three fields (i.e., irradiation of one field plus two additional fields). For example, each attendance for orthovoltage rotational therapy at the rate of 3 or more treatments per week would attract benefit under Item 15100 plus twice Item 15103.

T2.1.2 Benefits are attracted for an initial referred consultation and radiotherapy treatment where both take place at the same attendance.

T2.2 Brachytherapy of the Prostate (Item 15338)

T2.2.1 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.

T2.2.2 An approved site is one that has been licensed by the relevant Radiation Advisory Body.

T2.3 Intravascular Brachytherapy for Coronary Artery Restenoses (items 15360, 15363 and 15541)

T2.3.1 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, 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.

T2.4 Radiotherapy planning services (Items 15500 – 15562)

T2.4.1 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.

T2.4.2 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.

T2.4.3 Items 15500 to 15533 (inclusive) are for the purpose of a planning episode for 2D conformal radiotherapy. Items 15550 to 15562 (inclusive) are for the purpose of a planning episode for 3D conformal radiotherapy.

T2.4.4 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.

T2.4.5 The organs at risk must be clinically appropriate and clinical notes must contain information to support the use of a particular organ at risk.

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 an antenatal service.

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 an antenatal service.

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.

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 Pre-anaesthesia consultations are covered by items in the range 17610 - 17625.

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, analgaesia 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 Referred anaesthesia 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.

T6.2.4 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 Where an initial or subsequent consultation relates to the assessment and discussion of options for treatment and a cosmetic or other non-rebatable services are discussed, this would be considered a rebatable service under Medicare;

Where a consultation relates entirely to a cosmetic or other non-Medicare rebatable service (either before or after that service has taken place), then that consultation is not rebatable under Medicare; and

Any aftercare associated with a cosmetic or non-Medicare rebatable service is also not rebatable under Medicare.

T8.7.9 In respect of fractures, where the after-care is delegated to a doctor at a place other than the place where the initial reduction is carried out, benefit may be apportioned on a 50:50 basis rather than on the 75:25 basis suggested for surgical operations.

T8.7.10 Where the reduction of a fracture is carried out by hospital staff in the out-patient or casualty department of a recognised hospital and the patient is then referred to a private practitioner for supervision of the after-care, Medicare benefits are payable for the after-care treatment on an attendance basis.

T8.7.11 The following table shows the period which has been adopted as reasonable for the after-care of fractures:-

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

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
Femur	6 months
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months
Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks
Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

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

T8.8.1 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, 30680-30694, 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 Endoscopic Ultrasound +/- Fine Needle Aspiration (Item 30688-30694)

T8.24.1 The provider should make a record of the findings of the ultrasound imaging in the patient's notes for any service claimed against items 30688 to 30694.

T8.24.2 Endoscopic ultrasound is an appropriate investigation for patients in whom there is a strong clinical suspicion of pancreatic neoplasia with negative imaging (such as CT scanning). Scenarios include, but are not restricted to:

- A middle aged or elderly patient with a first attack of otherwise unexplained (eg negative abdominal CT) first episode of acute pancreatitis; or
- A patient with biochemical evidence of a neuroendocrine tumour.

The procedure is not claimable for periodic surveillance of patients at increased risk of pancreatic cancer, such as chronic pancreatitis. However, EUS would be appropriate for a patient with chronic pancreatitis in whom there was a clinical suspicion of pancreatic cancer (eg: a pancreatic mass occurring on a background of chronic pancreatitis).

T8.25 Removal of Skin Lesions (Items 31200 - 31355)

T8.25.1 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.

T8.25.2 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.

T8.25.3 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.

T8.25.4 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.

T8.25.5 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.

T8.25.6 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.

T8.25.7 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.

T8.25.8 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.

T8.25.9 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.

T8.25.10 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.

T8.25.11 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.

T8.25.12 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 that site of excision.

T8.25.13 It will be necessary for practitioners to retain copies of histological reports.

T8.25.14 Items 31245 and 31250 do not cover shave excision.

T8.26 Removal of Skin Lesion From Face (Items 31235-31245, 31265-31278, 31310-31320)

T8.26.1 For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

T8.27 Dissection of lymph nodes of neck (Items 31423 to 31438)

T8.27.1 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.

T8.28 Excision of Breast Lesions, Abnormalities or Tumours - malignant or benign (Items 31500 - 31515)

T8.28.1 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.

T8.29 Subcutaneous Mastectomy (Items 31521, 31524, 31527)

T8.29.1 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.

T8.29.2 Claims for benefits under item 45585 are not payable in association with 31521 or 31527.

T8.30 Fine Needle Aspiration of Breast Lesion (Item 31533)

T8.30.1 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.

T8.31 Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation (Items 31539, 31545)

T8.31.1 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.

T8.31.2 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.

T8.33 Per anal excision of rectal tumour using stereoscopic rectoscopy (Items 32103, 32104 and 32106)

T8.33.1 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.

T8.33.2 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.

T8.34 Sacral Nerve Stimulation for Faecal Incontinence (Items 32213 to 32218)

T8.34.1 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.

T8.35 Varicose veins, Multiple Injections of (Items 32500, 32501)

T8.35.1 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.)

T8.35.2 In items 32500 and 32501, it is sclerosant which is being injected.

T8.35.3 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.

T8.36 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 Item 35321 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, endovenous laser treatment for varicose veins.

T8.43 Vertebroplasty (Items 35400, 35402)

T8.43.1 Items 35400 and 35402 have been introduced on an interim basis for five years 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 until May 2011, 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, 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 Sacral Nerve Stimulation (Items 36658, 36660, and 36662)

T8.55.1 Items 36658, 36660, and 36662 only apply in the following circumstances:

- (a) the patient has received a sacral nerve stimulation implant for the management of refractory urinary incontinence or urge retention;
- (b) the patient requires replacement or removal of the pulse generator and/or leads for the neurostimulator device; and
- (c) the service referred to in paragraph (a) was rendered to the patient prior to 30 April 1998 and a Medicare benefit was paid for that service under item 30000, 39134, 39139 or 39140.

T8.56 Ureteroscopy (Item 36803)

T8.56.1 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).

T8.56.2 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).

T8.57 Selective Coronary Angiography (Items 38215-38246)

T8.57.1 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.

T8.57.2 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.

T8.57.3 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.

T8.57.4 Items in the range 38215 - 38246 cannot be claimed for any intravascular ultrasound (IVUS) procedure therefore Medicare Benefits are not payable for IVUS.

T8.58 Transurethral Needle Ablation (TUNA) of the Prostate (Items 37201 and 37202)

T8.58.1 Moderate to severe lower urinary tract symptoms are defined using the American Urological Association (AUA) Symptom Score or the International Prostate Symptom Score (IPSS).

T8.58.2 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.

T8.58.3 These items were introduced into the Schedule on an interim basis following a recommendation of the Medical Services Advisory Committee (MSAC). Interim funding is being provided to facilitate collection of Australian evidence of the long term effectiveness, cost-effectiveness and safety of these services. Data collection and analysis is being conducted by the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). Continuation of funding is dependent on the progress of this data collection. Therefore providers of these services are strongly encouraged to take part in the data collection process. Further information on the review of these items and the data collection process is available from the MSAC Secretariat (see para 8.4 of the General Explanatory Notes).

T8.59 Brachytherapy of the Prostate (Item 37220)

T8.59.1 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.

T8.59.2 An approved site is one that has been licensed by the relevant Radiation Advisory Body.

T8.60 High Dose Rate Brachytherapy (Item 37227)

T8.60.1 Item 37227 covers the service undertaken by a urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by a urologist, a radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

T8.61 Radical or Debulking Operation for Ovarian Tumour including Omentectomy (Item 35720)

T8.61.1 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.

T8.62 Transcutaneous Sperm Retrieval (Item 37605)

T8.62.1 Item 37605 covers transcutaneous sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies.

T8.62.2 Item 37605 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply, in accordance with point T8.5 of these Explanatory Notes.

T8.62.3 Where the procedure is carried out under local infiltration as the means of anaesthesia, additional benefit is not payable for the anaesthesia component as this is considered to be part of the procedure.

T8.63 Surgical sperm retrieval, by open approach (Item 37606)

T8.63.1 Item 37606 covers open sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies. Item 37606 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply.

T8.63.2 Benefits for item 37606 may be claimed in conjunction with a service or services provided under item 37605, where an open approach is clinically necessary following an unsuccessful percutaneous approach. Likewise, such services would be subject to the multiple operation rule.

T8.63.3 Benefit is not payable for item 37606 in conjunction with item 37604.

T8.64 Cardiac Pacemaker Insertion (Items 38209, 38212, 38353, 38356)

T8.64.1 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).

T8.65 Implantable ECG Loop Recorder (Item 38285)

T8.65.1 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.

T8.65.2 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).

T8.66 Transluminal Insertion of Stent or Stents (Item 38306)

T8.66.1 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.

T8.67 Permanent cardiac synchronisation device (Items 38365, 38368, 38654)

T8.67.1 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.

T8.68 Intravascular extraction of permanent pacing leads (Item 38358)

T8.68.1 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.

T8.69 Cardiac Resynchronisation Therapy (Item 38371)

T8.69.1 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.

T8.70 Implantable Cardioverter Defibrillator (Items 38384, 38387)

T8.70.1 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.

T8.71 Cardiac and Thoracic Surgical Items (38470 to 38766)

T8.71.1 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.

T8.72 Coronary Artery Bypass (Items 38497 - 38504)

T8.72.1 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.

T8.72.2 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.

T8.72.3 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.

T8.73 Re-operation via Median Sternotomy (Item 38640)

T8.73.1 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.

T8.74 Skull Base Surgery (Items 39640 - 39662)

T8.74.1 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.

T8.74.2 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.

T8.75 Intradiscal Injection of Chymopapain (Item 40336)

T8.75.1 The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

T8.76 Removal of Ventilating Tube from Ear (Item 41500)

T8.76.1 Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

T8.77 Meatoplasty (Item 41515)

T8.77.1 When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

T8.78 Reconstruction of Auditory Canal (Item 41524)

T8.78.1 When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

T8.79 Removal of Nasal Polyp or Polypi (Items 41662, 41665, 41668)

T8.79.1 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.

T8.80 Larynx, Direct Examination (Item 41846)

T8.80.1 Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

T8.81 Microlaryngoscopy (Item 41858)

T8.81.1 This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

T8.82 Imbedded Foreign Body (Item 42644)

T8.82.1 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.

T8.83 Corneal Incisions (Item 42672)

T8.83.1 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.

T8.84 Capsulectomy or Lensectomy (Item 42731)

T8.84.1 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		

T8.84.2 This list of exclusions was developed following consultation with the Royal Australian and New Zealand College of Ophthalmologists.

T8.85 Cyclodestructive Procedures (Items 42770 and 42771)

T8.85.1 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.)

T8.86 Laser Trabeculoplasty (Items 42782, 42783)

T8.86.1 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.)

T8.87 Laser Iridotomy (Items 42785, 42786)

T8.87.1 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.)

T8.88 Laser Capsulotomy (Items 42788, 42789)

T8.88.1 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.)

T8.89 Laser Vitreolysis or Corticolysis of lens material or Fibrinolysis (Items 42791, 42792)

T8.89.1 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.)

T8.90 Division of Suture by Laser (Item 42794)

T8.90.1 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.

T8.91 Laser Coagulation of Corneal or Scleral Blood Vessels (Item 42797)

T8.91.1 Benefits under this item are restricted to 4 treatments in a 2 year period. There is no provision for additional treatments in that period.

T8.91.2 Benefits are not payable under Item 42797 for procedures undertaken for cosmetic purposes (see paragraph 13.1.2 of the General Explanatory Notes).

T8.92 Ophthalmic Sutures (Item 42845)

T8.92.1 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.

T8.93 Full Face Chemical Peel (Items 45019, 45020)

T8.93.1 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.)

T8.94 Abrasive Therapy/Resurfacing (Items 45021 - 45026)

T8.94.1 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.

T8.94.2 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.

T8.94.3 Items 45025 and 45026 do not cover the use of fractional (Fraxel®) laser therapy.

T8.95 Foreign Implant (Item 45051)

T8.95.1 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.

T8.96 Escharotomy (Item 45054)

T8.96.1 Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

T8.97 Local Skin Flap – Definition

T8.97.1 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

T8.97.2 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.

T8.97.3 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.

T8.97.4 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.

T8.97.5 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.

T8.97.6 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.

T8.98 Free grafting to burns (Items 45406 - 45418)

T8.98.1 Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

T8.99 Revision of scar (Items 45506 to 45518)

T8.99.1 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.

T8.99.2 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.

T8.99.3 Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

T8.99.4 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.

T8.100 Reduction Mammoplasty (Item 45522)

T8.100.1 Medicare benefits are not payable under item 45522 for gynaecomastia. The treatment of gynaecomastia is provided for under either item 31527 or 45585.

T8.101 Augmentation Mammoplasty (Items 45524, 45527, 45528)

T8.101.1 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.

T8.101.2 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).

T8.102 Breast Reconstruction, Myocutaneous Flap (Item 45530)

T8.102.1 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.

T8.102.2 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.

T8.102.3 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*.

T8.103 Breast prosthesis, removal and replacement of (items 45552 - 45555)

T8.103.1 It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45552-45555 where the procedure is performed solely to increase breast size.

T8.104 Breast Ptosis (Items 45556, to 45559)

T8.104.1 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.

T8.104.2 Items 45557 and 45558 apply where correction of breast ptosis is indicated because the nipple is inferior to the infra-mammary groove.

T8.104.3 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.

T8.105 Nipple and/or Areola Reconstruction (Item 45545, 45546)

T8.105.1 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.

T8.105.2 Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

T8.106 Liposuction (Items 45584, 45585 and 45586)

T8.106.1 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.

T8.106.2 Where liposuction is indicated for the treatment of 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.)

T8.106.3 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.

T8.106.4 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.)

T8.107 Meloplasty for Correction of Facial Asymmetry (Items 45587, 45588)

T8.107.1 Benefits are payable under items 45587 and 45588 for face-lift operations performed to correct soft tissue abnormalities of the face due to causes other than the ageing process.

T8.107.2 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.)

T8.107.3 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.

T8.108 Reduction of Eyelids (Items 45617, 45620)

T8.108.1 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.

T8.109 Rhinoplasty (45638, 45639)

T8.109.1 Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

T8.109.2 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.

T8.109.3 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.)

T8.110 Contour Restoration (Item 45647)

T8.110.1 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.

T8.111 Vermilionectomy (Item 45669)

T8.111.1 Item 45669 covers treatment of the entire lip.

T8.112 Osteotomy of Jaw (Items 45720 - 45752)

T8.112.1 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.

T8.112.2 For the purposes of these items, a reference to maxilla includes the zygoma.

T8.113 Genioplasty (Items 45761)

T8.113.1 Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

T8.114 Tumour, cyst, ulcer or scar (Items 45801 - 45813)

T8.114.1 It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

T8.115 Fracture of Mandible or Maxilla (Items 45975 - 45996)

T8.115.1 There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

T8.116 Reduction of Dislocation or Fracture

T8.116.1 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.

T8.116.2 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.

T8.116.3 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.

T8.116.4 The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

T8.117 Lumbar Discectomy (Item 48636)

T8.117.1 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.

T8.118 Discectomy in relation to anterior interbody spinal fusion (Items 48660-48675)

T8.118.1 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.

T8.119 Internal Fixation (Items 48678-48690)

T8.119.1 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.

T8.120 Lumbar Artificial Intervertebral Total Disc Replacement (Items 48691-48693)

T8.120.1 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.

T8.121 Wrist Surgery (Items 49200-49227)

T8.121.1 For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

T8.122 Joint or other Synovial Cavity, Aspiration of, or Injection into (Items 50124, 50125)

T8.122.1 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.)

T8.122.2 Items 50124 - 50125 should not be claimed in association with arthroscopy items 48945-48960, 49118-49121, 49218-48227, 49360-49366, 49557-49566, 49700, 49703, 50100 and 50102.

T8.123 Paediatric patients (Items 50450 – 50658)

T8.123.1 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").

T8.124 Treatment of fractures in paediatric patients (Items 50500 – 50588)

T8.124.1 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.

T8.124.2 Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

T8.124.3 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.

T8.125 Non-resectable Hepatocellular Carcinoma Destruction of by Open or Laparoscopic Radiofrequency Ablation (50952)

T8.125.1 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.

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:

23072	<p>INITIATION AND MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) Fee: \$70.00 Benefit: 75% \$53.50 85% \$59.50 * The Fees and Benefits are shown as at 1 November 2006</p>
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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	<p>- 41 MINUTES to 45 MINUTES (3 units) Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$ 44.65 * The Fees and Benefits are shown as at 1 November 2006</p>
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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	<p>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 * The Fees and Benefits are shown as at 1 November 2006</p>
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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	<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 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 * The Fees and Benefits are shown as at 1 November 2006</p>
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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	<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) Fee: \$350.00 Benefit: 75% = \$262.50 85% = \$297.50 * The Fees and Benefits are shown as at 1 November 2006</p>
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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	<p>41 MINUTES TO 45 MINUTES (3 basic units) Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$ 44.65</p>
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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	<p>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 * The Fees and Benefits are shown as at 1 November 2006</p>
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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% = \$13.50	Benefit: 85% = \$14.90
23021	- 16 MINUTES TO 20 MINUTES (2 units) Fee: \$35.00	Benefit: 75% = \$26.25	Benefit: 85% = \$29.75
23022	- 21 MINUTES 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

* The Fees and Benefits are shown as at 1 November 2006

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

* The Fees and Benefits are shown as at 1 November 2006

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

* The Fees and Benefits are shown as at 1 November 2006

T10.4.3 Definition of Radical Surgery for the RVG

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

* The Fees and Benefits are shown as at 1 November 2006

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 meet 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	
13015	<p>HYPERBARIC OXYGEN THERAPY, for treatment of soft tissue radionecrosis or chronic or recurring wounds where hypoxia can be demonstrated, performed in a comprehensive hyperbaric 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> <p>Fee: \$230.05 Benefit: 75% = \$172.55 85% = \$195.55</p>
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> <p>Fee: \$233.70 Benefit: 75% = \$175.30 85% = \$198.65</p>
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> <p>Fee: \$104.50 Benefit: 75% = \$78.40 85% = \$88.85</p>
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> <p>Fee: \$147.60 Benefit: 75% = \$110.70 85% = \$125.50</p>
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> <p>Fee: \$123.40 Benefit: 75% = \$92.55 85% = \$104.90</p>
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> <p>Fee: \$64.30 Benefit: 75% = \$48.25 85% = \$54.70</p>
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> <p>Fee: \$133.65 Benefit: 85% = \$113.65</p>
13106	<p>DECLOTTING OF AN ARTERIOVENOUS SHUNT</p> <p>Fee: \$109.60 Benefit: 75% = \$82.20 85% = \$93.20</p>
13109	<p>INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)</p> <p>Fee: \$205.65 Benefit: 75% = \$154.25 85% = \$174.85</p>
13110	<p>TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes.)</p> <p>Fee: \$206.35 Benefit: 75% = \$154.80 85% = \$175.40</p>
13112	<p>PERITONEAL DIALYSIS, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.)</p> <p>Fee: \$123.40 Benefit: 75% = \$92.55 85% = \$104.90</p>

MISCELLANEOUS	ASSISTED REPRODUCTIVE SERVICES
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> <p>Fee: \$1,805.50 Benefit: 75% = \$1,354.15 85% = \$1,740.30</p>
13203	<p>OVULATION MONITORING SERVICES, for superovulated treatment cycles of less than 9 days duration and artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which item 13200, 13206, 13212, 13215 or 13218 applies (See para T1.4 of explanatory notes to this Category)</p> <p>Fee: \$451.40 Benefit: 75% = \$338.55 85% = \$386.20</p>
13206	<p>ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures), using unstimulated ovulation or ovulation stimulated only by clomiphene citrate, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies (See para T1.4 of explanatory notes to this Category)</p> <p>Fee: \$773.70 Benefit: 75% = \$580.30 85% = \$708.50</p>
13209	<p>PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies including in vitro fertilisation, gamete intrafallopian transfer and similar procedures, or for artificial insemination payable once only during 1 treatment cycle (See para T1.4 of explanatory notes to this Category)</p> <p>Fee: \$77.25 Benefit: 75% = \$57.95 85% = \$65.70</p>
13212	<p>OOCYTE RETRIEVAL by any means including laparoscopy or ultrasoundguided ova flushing, for the purposes of assisted reproductive technologies including in vitro fertilisation, gamete intra-fallopian transfer or similar procedures - only if rendered in conjunction with a service to which item 13200 or 13206 applies (Anaes.) (See para T1.4 of explanatory notes to this Category)</p> <p>Fee: \$328.90 Benefit: 75% = \$246.70 85% = \$279.60</p>
13215	<p>TRANSFER of EMBRYOS or both ova and sperm to the female reproductive system, by any means but excluding artificial insemination or the transfer of frozen or donated embryos - only if rendered in conjunction with a service to which item 13200 or 13206 applies, being services rendered in 1 treatment cycle (Anaes.) (See para T1.4 of explanatory notes to this Category)</p> <p>Fee: \$103.20 Benefit: 75% = \$77.40 85% = \$87.75</p>
13218	<p>PREPARATION AND TRANSFER of frozen or donated embryos or both ova and sperm, to the female reproductive system, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13203, 13206, 13212 or 13215 applies (Anaes.) (See para T1.4 of explanatory notes to this Category)</p> <p>Fee: \$773.70 Benefit: 75% = \$580.30 85% = \$708.50</p>
13221	<p>PREPARATION OF SEMEN for the purposes of assisted reproductive technologies or for artificial insemination (See para T1.4 of explanatory notes to this Category)</p> <p>Fee: \$47.10 Benefit: 75% = \$35.35 85% = \$40.05</p>
13251	<p>INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which item 13218 applies. (See para T1.4 of explanatory notes to this Category)</p> <p>Fee: \$388.35 Benefit: 75% = \$291.30 85% = \$330.10</p>
13290	<p>SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required</p> <p>Fee: \$184.45 Benefit: 75% = \$138.35 85% = \$156.80</p>
13292	<p>SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.)</p> <p>Fee: \$369.10 Benefit: 75% = \$276.85 85% = \$313.75</p>

MISCELLANEOUS		PAEDIATRIC & NEONATAL	
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: \$51.45	Benefit: 75% = \$38.60	85% = \$43.75
13303	UMBILICAL ARTERY CATHETERISATION with or without infusion Fee: \$76.25	Benefit: 75% = \$57.20	85% = \$64.85
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor Fee: \$301.65	Benefit: 75% = \$226.25	85% = \$256.45
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected Fee: \$257.25	Benefit: 75% = \$192.95	85% = \$218.70
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS Fee: \$25.65	Benefit: 75% = \$19.25	85% = \$21.85
13318	CENTRAL VEIN CATHETERISATION (via jugular or subclavian vein) - by open exposure in a person under 12 years of age (Anaes.) Fee: \$205.40	Benefit: 75% = \$154.05	85% = \$174.60
13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.) Fee: \$205.40	Benefit: 75% = \$154.05	85% = \$174.60
SUBGROUP 5 - CARDIOVASCULAR			
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.) Fee: \$87.45	Benefit: 75% = \$65.60	85% = \$74.35
SUBGROUP 6 - GASTROENTEROLOGY			
13500	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant IN THE ABSENCE OF GASTROINTESTINAL HAEMORRHAGE Fee: \$162.85	Benefit: 75% = \$122.15	85% = \$138.45
13503	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant FOR UPPER GASTROINTESTINAL HAEMORRHAGE Fee: \$325.70	Benefit: 75% = \$244.30	85% = \$276.85
13506	GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices Fee: \$166.60	Benefit: 75% = \$124.95	85% = \$141.65
SUBGROUP 8 - HAEMATOLOGY			
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) Fee: \$301.00	Benefit: 75% = \$225.75	85% = \$255.85
13703	ADMINISTRATION OF BLOOD, including collection from donor Fee: \$107.85	Benefit: 75% = \$80.90	85% = \$91.70
13706	ADMINISTRATION OF BLOOD or bone marrow already collected (See para T1.5 of explanatory notes to this Category) Fee: \$75.30	Benefit: 75% = \$56.50	85% = \$64.05
13709	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation (See para T1.6 of explanatory notes to this Category) Fee: \$43.75	Benefit: 75% = \$32.85	85% = \$37.20

MISCELLANEOUS	INTENSIVE CARE
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 <i>(See para T1.8 of explanatory notes to this Category)</i> Fee: \$132.20 Benefit: 75% = \$99.15 85% = \$112.40</p>
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	<p>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: \$327.05 Benefit: 75% = \$245.30 85% = \$278.00</p>
13873	<p>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: \$242.60 Benefit: 75% = \$181.95 85% = \$206.25</p>
13876	<p>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: \$69.40 Benefit: 75% = \$52.05 85% = \$59.00</p>
13881	<p>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: \$132.20 Benefit: 75% = \$99.15 85% = \$112.40</p>
13882	<p>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: \$104.10 Benefit: 75% = \$78.10 85% = \$88.50</p>
13885	<p>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: \$138.80 Benefit: 75% = \$104.10 85% = \$118.00</p>
13888	<p>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: \$69.40 Benefit: 75% = \$52.05 85% = \$59.00</p>
SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES	
13915	<p>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: \$58.75 Benefit: 75% = \$44.10 85% = \$49.95</p>
13918	<p>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: \$88.40 Benefit: 75% = \$66.30 85% = \$75.15</p>

MISCELLANEOUS		OTHER
14109	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 50cm ² and up to 100cm ² (Anaes.) (See para T1.13 of explanatory notes to this Category)	Fee: \$169.15 Benefit: 75% = \$126.90 85% = \$143.80
14112	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 100cm ² and up to 150cm ² (Anaes.) (See para T1.13 of explanatory notes to this Category)	Fee: \$200.30 Benefit: 75% = \$150.25 85% = \$170.30
14115	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 150cm ² and up to 250cm ² (Anaes.) (See para T1.13 of explanatory notes to this Category)	Fee: \$231.60 Benefit: 75% = \$173.70 85% = \$196.90
14118	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 250cm ² (Anaes.) (See para T1.13 of explanatory notes to this Category)	Fee: \$294.25 Benefit: 75% = \$220.70 85% = \$250.15
14124	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)	Fee: \$137.70 Benefit: 75% = \$103.30 85% = \$117.05
SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES		
14200	GASTRIC LAVAGE in the treatment of ingested poison	Fee: \$54.05 Benefit: 75% = \$40.55 85% = \$45.95
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)	Fee: \$46.20 Benefit: 75% = \$34.65 85% = \$39.30
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula	Fee: \$32.15 Benefit: 75% = \$24.15 85% = \$27.35
14209	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent	Fee: \$80.10 Benefit: 75% = \$60.10 85% = \$68.10
14212	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.)	Fee: \$167.35 Benefit: 75% = \$125.55 85% = \$142.25
14215	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, accessing of to add or remove fluid	Fee: \$88.40 Benefit: 75% = \$66.30 85% = \$75.15
14218	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain	Fee: \$88.40 Benefit: 75% = \$66.30 85% = \$75.15
14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies	Fee: \$47.40 Benefit: 75% = \$35.55 85% = \$40.30
14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)	Fee: \$63.55 Benefit: 75% = \$47.70 85% = \$54.05

MISCELLANEOUS		OTHER
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: \$88.40 Benefit: 75% = \$66.30 85% = \$75.15</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: \$269.15 Benefit: 75% = \$201.90</p>	
14233	<p>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.) (See para T1.14 of explanatory notes to this Category)</p> <p>Fee: \$326.85 Benefit: 75% = \$245.15</p>	
14236	<p>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.) (See para T1.14 of explanatory notes to this Category)</p> <p>Fee: \$596.00 Benefit: 75% = \$447.00</p>	
14239	<p>Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.) (See para T1.14 of explanatory notes to this Category)</p> <p>Fee: \$144.00 Benefit: 75% = \$108.00</p>	
14242	<p>SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of severe chronic spasticity (Anaes.) (See para T1.14 of explanatory notes to this Category)</p> <p>Fee: \$427.75 Benefit: 75% = \$320.85</p>	
‡ 14245	<p>IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme (See para T1.15 of explanatory notes to this Category)</p> <p>Fee: \$88.40 Benefit: 75% = \$66.30 85% = \$75.15</p>	

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: \$38.45	Benefit: 75% = \$28.85	85% = \$32.70
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 \$15.45		
15006	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field Fee: \$85.25	Benefit: 75% = \$63.95	85% = \$72.50
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 \$16.75		
15012	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye - 1 field Fee: \$48.25	Benefit: 75% = \$36.20	85% = \$41.05
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: \$43.10	Benefit: 75% = \$32.35	85% = \$36.65
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 \$17.00		
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field Fee: \$50.85	Benefit: 75% = \$38.15	85% = \$43.25
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 \$20.50		
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field - 1 field Fee: \$108.60	Benefit: 75% = \$81.45	85% = \$92.35
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 \$42.70		
SUBGROUP 3 - MEGAVOLTAGE			
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field Fee: \$49.40	Benefit: 75% = \$37.05	85% = \$42.00
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 \$28.80		
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: \$53.90	Benefit: 75% = \$40.45	85% = \$45.85
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: \$53.90	Benefit: 75% = \$40.45	85% = \$45.85

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: \$53.90 Benefit: 75% = \$40.45 85% = \$45.85	
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: \$53.90 Benefit: 75% = \$40.45 85% = \$45.85	
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: \$53.90 Benefit: 75% = \$40.45 85% = \$45.85	
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 \$34.25	
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 \$34.25	
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 \$34.25	
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 \$34.25	
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 \$34.25	
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: \$53.90 Benefit: 75% = \$40.45 85% = \$45.85	
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: \$53.90 Benefit: 75% = \$40.45 85% = \$45.85	
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: \$53.90 Benefit: 75% = \$40.45 85% = \$45.85	
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: \$53.90 Benefit: 75% = \$40.45 85% = \$45.85	
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: \$53.90 Benefit: 75% = \$40.45 85% = \$45.85	
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 \$34.25	

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: \$652.00 Benefit: 75% = \$489.00 85% = \$586.80		
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: \$709.35 Benefit: 75% = \$532.05 85% = \$644.15		
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: \$709.35 Benefit: 75% = \$532.05 85% = \$644.15		
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: \$673.50 Benefit: 75% = \$505.15 85% = \$608.30		
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: \$673.50 Benefit: 75% = \$505.15 85% = \$608.30		
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: \$611.25 Benefit: 75% = \$458.45 85% = \$546.05		
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: \$611.25 Benefit: 75% = \$458.45 85% = \$546.05		
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 7 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 T2.2 of explanatory notes to this Category)</i> Fee: \$844.90 Benefit: 75% = \$633.70 85% = \$779.70		
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) Fee: \$68.85 Benefit: 75% = \$51.65 85% = \$58.55		
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: \$171.85 Benefit: 75% = \$128.90 85% = \$146.10		
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: \$458.60 Benefit: 75% = \$343.95 85% = \$393.40		
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance Fee: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85		
15351	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface Fee: \$105.30 Benefit: 75% = \$79.00 85% = \$89.55		
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface Fee: \$127.80 Benefit: 75% = \$95.85 85% = \$108.65		
15357	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 each attendance Fee: \$36.15 Benefit: 75% = \$27.15 85% = \$30.75		

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 T2.3 of explanatory notes to this Category)</i>	Fee: \$326.00	Benefit: 75% = \$244.50 85% = \$277.10
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 T2.3 of explanatory notes to this Category)</i>	Fee: \$326.00	Benefit: 75% = \$244.50 85% = \$277.10
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 T2.4 of explanatory notes to this Category)</i>	Fee: \$219.15	Benefit: 75% = \$164.40 85% = \$186.30
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 T2.4 of explanatory notes to this Category)</i>	Fee: \$281.40	Benefit: 75% = \$211.05 85% = \$239.20
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 T2.4 of explanatory notes to this Category)</i>	Fee: \$420.20	Benefit: 75% = \$315.15 85% = \$357.20
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 T2.4 of explanatory notes to this Category)</i>	Fee: \$189.95	Benefit: 75% = \$142.50 85% = \$161.50
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 T2.4 of explanatory notes to this Category)</i>	Fee: \$244.85	Benefit: 75% = \$183.65 85% = \$208.15
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: \$276.90	Benefit: 75% = \$207.70 85% = \$235.40
15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies) <i>(See para T2.4 of explanatory notes to this Category)</i>	Fee: \$354.45	Benefit: 75% = \$265.85 85% = \$301.30
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 T2.4 of explanatory notes to this Category)</i>	Fee: \$69.50	Benefit: 75% = \$52.15 85% = \$59.10
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 T2.4 of explanatory notes to this Category)</i>	Fee: \$306.95	Benefit: 75% = \$230.25 85% = \$260.95

RADIATION ONCOLOGY	COMPUTERISED PLANNING
15524	<p>RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields (See para T2.4 of explanatory notes to this Category) Fee: \$575.55 Benefit: 75% = \$431.70 85% = \$510.35</p>
15527	<p>RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks (See para T2.4 of explanatory notes to this Category) Fee: \$71.30 Benefit: 75% = \$53.50 85% = \$60.65</p>
15530	<p>RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used (See para T2.4 of explanatory notes to this Category) Fee: \$318.00 Benefit: 75% = \$238.50 85% = \$270.30</p>
15533	<p>RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields (See para T2.4 of explanatory notes to this Category) Fee: \$603.00 Benefit: 75% = \$452.25 85% = \$537.80</p>
15536	<p>BRACHYTHERAPY PLANNING, computerised radiation dosimetry (See para T2.4 of explanatory notes to this Category) Fee: \$241.00 Benefit: 75% = \$180.75 85% = \$204.85</p>
15539	<p>BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338 Fee: \$566.50 Benefit: 75% = \$424.90 85% = \$501.30</p>
15541	<p>CATHETER BASED INTRAVASCULAR BRACHYTHERAPY PLANNING: computerised radiation dosimetry. The procedure must be performed by a radiation oncologist in association with a cardiologist and be associated with a service to which item 38321, 38324, 38327 or 38330 applies. (See para T2.3 of explanatory notes to this Category) Fee: \$241.00 Benefit: 75% = \$180.75 85% = \$204.85</p>
15550	<p>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 (See para T2.4 of explanatory notes to this Category) Fee: \$594.75 Benefit: 75% = \$446.10 85% = \$529.55</p>
15553	<p>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 (See para T2.4 of explanatory notes to this Category) Fee: \$641.70 Benefit: 75% = \$481.30 85% = \$576.50</p>

RADIATION ONCOLOGY	STEREOTACTIC RADIOSURGERY
15556	<p>DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where:</p> <ul style="list-style-type: none"> (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 (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 (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 (d) dose volume histograms must be generated, approved and recorded with the plan; and (e) a CT image volume dataset must be used for the relevant region to be planned and treated; and (f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images <p><i>(See para T2.4 of explanatory notes to this Category)</i></p> <p>Fee: \$600.00 Benefit: 75% = \$450.00 85% = \$534.80</p>
15559	<p>DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where:</p> <ul style="list-style-type: none"> (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 (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 (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>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 T2.4 of explanatory notes to this Category)</i></p> <p>Fee: \$782.60 Benefit: 75% = \$586.95 85% = \$717.40</p>
15562	<p>DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where:</p> <ul style="list-style-type: none"> (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 (b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and <ul style="list-style-type: none"> (i) two planning target volumes; or (ii) two organ at risk dose goals or constraints defined in the prescription. <p>or</p> <ul style="list-style-type: none"> (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>or</p> <ul style="list-style-type: none"> (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>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 T2.4 of explanatory notes to this Category)</i></p> <p>Fee: \$1,012.15 Benefit: 75% = \$759.15 85% = \$946.95</p>
SUBGROUP 6 - STEREOTACTIC RADIOSURGERY	
15600	<p>STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment</p> <p>Fee: \$1,537.35 Benefit: 75% = \$1,153.05 85% = \$1,472.15</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: \$587.50	Benefit: 75% = \$440.65 85% = \$522.30
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique	Fee: \$451.45	Benefit: 75% = \$338.60 85% = \$386.25
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique	Fee: \$308.10	Benefit: 75% = \$231.10 85% = \$261.90
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32	Fee: \$266.55	Benefit: 75% = \$199.95 85% = \$226.60
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: \$3,689.75	Benefit: 75% = \$2,767.35 85% = \$3,624.55
16018	ADMINISTRATION OF ¹⁵³ SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) from either:- (i) carcinoma of the prostate, where hormonal therapy has failed; or (ii) carcinoma of the breast, where both hormonal therapy and chemotherapy have failed; <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: \$2,205.70	Benefit: 75% = \$1,654.30 85% = \$2,140.50

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: \$313.05 Benefit: 75% = \$234.80 85% = \$266.10	
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: \$482.05 Benefit: 75% = \$361.55 85% = \$416.85	
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: \$563.40 Benefit: 75% = \$422.55 85% = \$498.20	
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: \$1,131.85 Benefit: 75% = \$848.90 85% = \$1,066.65	
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: \$267.00 Benefit: 75% = \$200.25 85% = \$226.95	
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: \$196.85 Benefit: 75% = \$147.65 85% = \$167.35	
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: \$287.95 Benefit: 75% = \$216.00 85% = \$244.80	
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: \$375.70 Benefit: 75% = \$281.80 85% = \$319.35	
16571	CERVIX, repair of extensive laceration or lacerations (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$287.95 Benefit: 75% = \$216.00 85% = \$244.80	
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: \$234.65 Benefit: 75% = \$176.00 85% = \$199.50	
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: \$117.05 Benefit: 75% = \$87.80 85% = \$99.50	

OBSTETRICS		OBSTETRICS	
	INTERVENTIONAL TECHNIQUES		
16600	AMNIOCENTESIS, diagnostic (See para T4.8 of explanatory notes to this Category) Fee: \$57.35	Benefit: 75% = \$43.05	85% = \$48.75
16603	CHORIONIC VILLUS SAMPLING, by any route (See para T4.8 of explanatory notes to this Category) Fee: \$110.05	Benefit: 75% = \$82.55	85% = \$93.55
16606	FETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.) (See para T4.8 of explanatory notes to this Category) Fee: \$219.65	Benefit: 75% = \$164.75	85% = \$186.75
16609	FETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.) (See para T4.8 of explanatory notes to this Category) Fee: \$447.90	Benefit: 75% = \$335.95	85% = \$382.70
16612	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.) (See para T4.8 of explanatory notes to this Category) Fee: \$352.40	Benefit: 75% = \$264.30	85% = \$299.55
16615	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.) (See para T4.8 of explanatory notes to this Category) Fee: \$187.70	Benefit: 75% = \$140.80	85% = \$159.55
16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated (See para T4.8 of explanatory notes to this Category) Fee: \$187.70	Benefit: 75% = \$140.80	85% = \$159.55
16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios (See para T4.8 of explanatory notes to this Category) Fee: \$187.70	Benefit: 75% = \$140.80	85% = \$159.55
16624	FETAL FLUID FILLED CAVITY, drainage of (See para T4.8 of explanatory notes to this Category) Fee: \$270.10	Benefit: 75% = \$202.60	85% = \$229.60
16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis (See para T4.8 of explanatory notes to this Category) Fee: \$549.95	Benefit: 75% = \$412.50	85% = \$484.75
16633	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606, 16609, 16612, 16615 and 16627 (See para T4.8 of explanatory notes to this Category) Derived Fee: 50% of the fee for the first foetus for any additional foetus tested		
16636	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600, 16603, 16618, 16621 and 16624 (See para T4.8 of explanatory notes to this Category) Derived Fee: 50% of the fee for the first foetus for any additional foetus tested		

ANAESTHETICS

CONSULTATIONS

17650	<ul style="list-style-type: none"> - 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 <p><i>(See para T6.2 of explanatory notes to this Category)</i></p> <p>Fee: \$107.05 Benefit: 75% = \$80.30 85% = \$91.00</p>
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. <p><i>(See para T6.2 of explanatory notes to this Category)</i></p> <p>Fee: \$136.30 Benefit: 75% = \$102.25 85% = \$115.90</p>
17680	<p style="text-align: center;">ANAESTHETIST, CONSULTATION, OTHER</p> <p>(Professional attendance by an anaesthetist in the practice of ANAESTHESIA)</p> <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. <p><i>(See para T6.3 of explanatory notes to this Category)</i></p> <p>Fee: \$77.25 Benefit: 75% = \$57.95 85% = \$65.70</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; 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.</p> <p><i>(See para T6.3 of explanatory notes to this Category)</i></p> <p>Fee: \$35.75 Benefit: 75% = \$26.85 85% = \$30.40</p>

REGIONAL OR FIELD NERVE BLOCKS		REGIONAL OR FIELD NERVE BLOCKS	
18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) (See para T7.5 of explanatory notes to this Category) Fee: \$34.00 Benefit: 75% = \$25.50 85% = \$28.90		
18244	VAGUS NERVE, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$91.00 Benefit: 75% = \$68.25 85% = \$77.35		
18246	GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$91.00 Benefit: 75% = \$68.25 85% = \$77.35		
18248	PHRENIC NERVE, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$80.05 Benefit: 75% = \$60.05 85% = \$68.05		
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$56.45 Benefit: 75% = \$42.35 85% = \$48.00		
18252	CERVICAL PLEXUS, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$91.00 Benefit: 75% = \$68.25 85% = \$77.35		
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$91.00 Benefit: 75% = \$68.25 85% = \$77.35		
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$56.45 Benefit: 75% = \$42.35 85% = \$48.00		
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$56.45 Benefit: 75% = \$42.35 85% = \$48.00		
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$80.05 Benefit: 75% = \$60.05 85% = \$68.05		
18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.) (See para T7.5 of explanatory notes to this Category) Fee: \$56.45 Benefit: 75% = \$42.35 85% = \$48.00		
18264	PUDENDAL NERVE, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$91.00 Benefit: 75% = \$68.25 85% = \$77.35		
18266	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block (See para T7.5 of explanatory notes to this Category) Fee: \$56.45 Benefit: 75% = \$42.35 85% = \$48.00		
18268	OBTURATOR NERVE, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$80.05 Benefit: 75% = \$60.05 85% = \$68.05		
18270	FEMORAL NERVE, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$80.05 Benefit: 75% = \$60.05 85% = \$68.05		
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent (See para T7.5 of explanatory notes to this Category) Fee: \$56.45 Benefit: 75% = \$42.35 85% = \$48.00		

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: \$80.05	Benefit: 75% = \$60.05 85% = \$68.05
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
18278	SCIATIC NERVE, injection of an anaesthetic agent <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$80.05	Benefit: 75% = \$60.05 85% = \$68.05
18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.) <i>(See para T7.5 of explanatory notes to this Category)</i>	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
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: \$91.00	Benefit: 75% = \$68.25 85% = \$77.35
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: \$133.35	Benefit: 75% = \$100.05 85% = \$113.35
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: \$133.35	Benefit: 75% = \$100.05 85% = \$113.35
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: \$133.35	Benefit: 75% = \$100.05 85% = \$113.35
18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.)	Fee: \$225.55	Benefit: 75% = \$169.20 85% = \$191.75
18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin (Anaes.)	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)	Fee: \$158.90	Benefit: 75% = \$119.20 85% = \$135.10
18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	Fee: \$135.95	Benefit: 75% = \$102.00 85% = \$115.60
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	Fee: \$158.90	Benefit: 75% = \$119.20 85% = \$135.10

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 (See para T11 of explanatory notes to this Category)	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
18351	BOTULINUM TOXIN (Dysport), injection of, for the treatment of hemifacial spasm in a patient 18 years of age or older, including all such injections on any one day (See para T11 of explanatory notes to this Category)	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
18352	BOTULINUM TOXIN (Botox or Dysport), injection of, for cervical dystonia (spasmodic torticollis), including all injections on any one day (See para T11 of explanatory notes to this Category)	Fee: \$225.55	Benefit: 75% = \$169.20 85% = \$191.75
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.) (See para T11 of explanatory notes to this Category)	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
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.) (See para T11 of explanatory notes to this Category)	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
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.) (See para T11 of explanatory notes to this Category)	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
18360	BOTULINUM TOXIN (Botox), injection of, for the treatment of focal spasticity in adults, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb) (See para T11 of explanatory notes to this Category)	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
18362	BOTULINUM TOXIN (Botox), injection of, for the treatment of severe primary hyperhidrosis of the axillae, including all such injections on any one day (Anaes.) (See para T11 of explanatory notes to this Category)	Fee: \$222.80	Benefit: 75% = \$167.10 85% = \$189.40
18364	BOTULINUM TOXIN (Dysport), injection of, for treatment of spasticity of the arm in adults following a stroke, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb) (See para T11 of explanatory notes to this Category)	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
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.) (See para T11 of explanatory notes to this Category)	Fee: \$141.30	Benefit: 75% = \$106.00 85% = \$120.15
18368	BOTULINUM TOXIN (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day (See para T11 of explanatory notes to this Category)	Fee: \$241.15	Benefit: 75% = \$180.90 85% = \$205.00

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: \$40.70 Benefit: 75% = \$30.55 85% = \$34.60
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: \$40.70 Benefit: 75% = \$30.55 85% = \$34.60
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: \$112.75 Benefit: 75% = \$84.60 85% = \$95.85
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: \$112.75 Benefit: 75% = \$84.60 85% = \$95.85

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: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
20102	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
20104	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
20124	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
20142	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
20143	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
20144	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (8 basic units) Fee: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
20145	INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (8 basic units) Fee: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
20146	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
20148	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
20162	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on the nose and accessory sinuses (7 basic units) Fee: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
20164	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
20172	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units) Fee: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
20174	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units) Fee: \$161.10 Benefit: 75% = \$120.85 85% = \$136.95	

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: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
20702	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
20705	INITIATION OF MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopy procedures (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
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: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
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: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
20740	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
20745	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
20752	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
20754	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units) Fee: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
20756	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units) Fee: \$161.10 Benefit: 75% = \$120.85 85% = \$136.95	
20770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units) Fee: \$268.50 Benefit: 75% = \$201.40 85% = \$228.25	
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: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
20791	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastric reduction or gastroplasty for the treatment of morbid obesity (10 basic units) Fee: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15	
20792	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units) Fee: \$232.70 Benefit: 75% = \$174.55 85% = \$197.80	
20793	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units) Fee: \$268.50 Benefit: 75% = \$201.40 85% = \$228.25	
20794	INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units) Fee: \$214.80 Benefit: 75% = \$161.10 85% = \$182.60	

RELATIVE VALUE GUIDE		LOWER ABDOMEN
20798	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units) Fee: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15	
20799	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
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: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
20802	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
20805	INITIATION OF MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopic procedures (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
20806	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units) Fee: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
20810	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
20815	INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
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: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
20832	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
20840	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures within the peritoneal cavity in lower abdomen including appendicectomy, not being a service to which another item in this Subgroup applies (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
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: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
20842	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15	
20845	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units) Fee: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15	
20846	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units) Fee: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15	

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: \$71.60	Benefit: 75% = \$53.70	85% = \$60.90
21200	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units) Fee: \$71.60	Benefit: 75% = \$53.70	85% = \$60.90
21202	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4 basic units) Fee: \$71.60	Benefit: 75% = \$53.70	85% = \$60.90
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: \$107.40	Benefit: 75% = \$80.55	85% = \$91.30
21212	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units) Fee: \$179.00	Benefit: 75% = \$134.25	85% = \$152.15
21214	INITIATION OF MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 basic units) Fee: \$179.00	Benefit: 75% = \$134.25	85% = \$152.15
21216	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic units) Fee: \$250.60	Benefit: 75% = \$187.95	85% = \$213.05
21220	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital (4 basic units) Fee: \$71.60	Benefit: 75% = \$53.70	85% = \$60.90
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: \$107.40	Benefit: 75% = \$80.55	85% = \$91.30
21232	INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units) Fee: \$89.50	Benefit: 75% = \$67.15	85% = \$76.10
21234	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur (8 basic units) Fee: \$143.20	Benefit: 75% = \$107.40	85% = \$121.75
21260	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units) Fee: \$71.60	Benefit: 75% = \$53.70	85% = \$60.90
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: \$143.20	Benefit: 75% = \$107.40	85% = \$121.75
21272	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units) Fee: \$71.60	Benefit: 75% = \$53.70	85% = \$60.90
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: \$107.40	Benefit: 75% = \$80.55	85% = \$91.30
21280	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg (15 basic units) Fee: \$268.50	Benefit: 75% = \$201.40	85% = \$228.25
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: \$53.70	Benefit: 75% = \$40.30	85% = \$45.65
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: \$71.60	Benefit: 75% = \$53.70	85% = \$60.90

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: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
21634	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units) Fee: \$161.10 Benefit: 75% = \$120.85 85% = \$136.95	
21636	INITIATION OF MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) amputation (15 basic units) Fee: \$268.50 Benefit: 75% = \$201.40 85% = \$228.25	
21638	INITIATION OF MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units) Fee: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15	
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: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
21652	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm (10 basic units) Fee: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15	
21654	INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units) Fee: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
21656	INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units) Fee: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15	
21670	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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 (3 basic units) Fee: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
21682	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder spica application when undertaken in a hospital (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
21712	INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
21714	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
21716	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
21730	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital (3 basic units) Fee: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
21732	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	

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: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
21760	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units) Fee: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
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: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
21772	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
21790	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm (15 basic units) Fee: \$268.50 Benefit: 75% = \$201.40 85% = \$228.25	
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: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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 (3 basic units) Fee: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
21832	INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units) Fee: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
21834	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
21842	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
21870	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, wrist or hand (15 basic units) Fee: \$268.50 Benefit: 75% = \$201.40 85% = \$228.25	
21872	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8 basic units) Fee: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	

RELATIVE VALUE GUIDE		MISCELLANEOUS
21962	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
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: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
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: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
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: \$268.50 Benefit: 75% = \$201.40 85% = \$228.25	
21973	INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
21976	INITIATION OF MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
21980	INITIATION OF MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
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: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
22008	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER , insertion of when performed in association with the administration of anaesthesia (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90	
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: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65	

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: \$53.70	Benefit: 75% = \$40.30 85% = \$45.65
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: \$107.40	Benefit: 75% = \$80.55 85% = \$91.30
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: \$125.30	Benefit: 75% = \$94.00 85% = \$106.55
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: \$71.60	Benefit: 75% = \$53.70 85% = \$60.90
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: \$71.60	Benefit: 75% = \$53.70 85% = \$60.90
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: \$89.50	Benefit: 75% = \$67.15 85% = \$76.10
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: \$53.70	Benefit: 75% = \$40.30 85% = \$45.65
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: \$35.80	Benefit: 75% = \$26.85 85% = \$30.45
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: \$53.70	Benefit: 75% = \$40.30 85% = \$45.65
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: \$35.80	Benefit: 75% = \$26.85 85% = \$30.45
22055	<p>PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent (12 basic units)</p>	Fee: \$214.80	Benefit: 75% = \$161.10 85% = \$182.60
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: \$358.00	Benefit: 75% = \$268.50 85% = \$304.30
22065	<p>INDUCED CONTROLLED HYPOTHERMIA total body (5 basic units) (See para T10.10 of explanatory notes to this Category)</p>	Fee: \$89.50	Benefit: 75% = \$67.15 85% = \$76.10

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: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15		
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: \$268.50 Benefit: 75% = \$201.40 85% = \$228.25		
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: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30		
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: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30		
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: \$17.90 Benefit: 75% = \$13.45 85% = \$15.25		
23021	16 MINUTES TO 20 MINUTES (2 basic units) Fee: \$35.80 Benefit: 75% = \$26.85 85% = \$30.45		
23022	21 MINUTES TO 25 MINUTES (2 basic units) Fee: \$35.80 Benefit: 75% = \$26.85 85% = \$30.45		
23023	26 MINUTES TO 30 MINUTES (2 basic units) Fee: \$35.80 Benefit: 75% = \$26.85 85% = \$30.45		
23031	31 MINUTES TO 35 MINUTES (3 basic units) Fee: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65		
23032	36 MINUTES TO 40 MINUTES (3 basic units) Fee: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65		
23033	41 MINUTES TO 45 MINUTES (3 basic units) Fee: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65		
23041	46 MINUTES TO 50 MINUTES (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90		
23042	51 MINUTES TO 55 MINUTES (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90		
23043	56 MINUTES TO 1:00 HOUR (4 basic units) Fee: \$71.60 Benefit: 75% = \$53.70 85% = \$60.90		
23051	1:01 HOURS TO 1:05 HOURS (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10		
23052	1:06 HOURS TO 1:10 HOURS (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10		

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
23053	1:11 HOURS TO 1:15 HOURS (5 basic units) Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10	
23061	1:16 HOURS TO 1:20 HOURS (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
23062	1:21 HOURS TO 1:25 HOURS (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
23063	1:26 HOURS TO 1:30 HOURS (6 basic units) Fee: \$107.40 Benefit: 75% = \$80.55 85% = \$91.30	
23071	1:31 HOURS TO 1:35 HOURS (7 basic units) Fee: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
23072	1:36 HOURS TO 1:40 HOURS (7 basic units) Fee: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
23073	1:41 HOURS TO 1:45 HOURS (7 basic units) Fee: \$125.30 Benefit: 75% = \$94.00 85% = \$106.55	
23081	1:46 HOURS TO 1:50 HOURS (8 basic units) Fee: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
23082	1:51 HOURS TO 1:55 HOURS (8 basic units) Fee: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
23083	1:56 HOURS TO 2:00 HOURS (8 basic units) Fee: \$143.20 Benefit: 75% = \$107.40 85% = \$121.75	
23091	2:01 HOURS TO 2:10 HOURS (9 basic units) Fee: \$161.10 Benefit: 75% = \$120.85 85% = \$136.95	
23101	2:11 HOURS TO 2:20 HOURS (10 basic units) Fee: \$179.00 Benefit: 75% = \$134.25 85% = \$152.15	
23111	2:21 HOURS TO 2:30 HOURS (11 basic units) Fee: \$196.90 Benefit: 75% = \$147.70 85% = \$167.40	
23112	2:31 HOURS TO 2:40 HOURS (12 basic units) Fee: \$214.80 Benefit: 75% = \$161.10 85% = \$182.60	
23113	2:41 HOURS TO 2:50 HOURS (13 basic units) Fee: \$232.70 Benefit: 75% = \$174.55 85% = \$197.80	
23114	2:51 HOURS TO 3:00 HOURS (14 basic units) Fee: \$250.60 Benefit: 75% = \$187.95 85% = \$213.05	
23115	3:01 HOURS TO 3:10 HOURS (15 basic units) Fee: \$268.50 Benefit: 75% = \$201.40 85% = \$228.25	
23116	3:11 HOURS TO 3:20 HOURS (16 basic units) Fee: \$286.40 Benefit: 75% = \$214.80 85% = \$243.45	
23117	3:21 HOURS TO 3:30 HOURS (17 basic units) Fee: \$304.30 Benefit: 75% = \$228.25 85% = \$258.70	
23118	3:31 HOURS TO 3:40 HOURS (18 basic units) Fee: \$322.20 Benefit: 75% = \$241.65 85% = \$273.90	
23119	3:41 HOURS TO 3:50 HOURS (19 basic units) Fee: \$340.10 Benefit: 75% = \$255.10 85% = \$289.10	
23121	3:51 HOURS TO 4:00 HOURS (20 basic units) Fee: \$358.00 Benefit: 75% = \$268.50 85% = \$304.30	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
23170	4:01 HOURS TO 4:10 HOURS (21 basic units) Fee: \$375.90 Benefit: 75% = \$281.95 85% = \$319.55	
23180	4:11 HOURS TO 4:20 HOURS (22 basic units) Fee: \$393.80 Benefit: 75% = \$295.35 85% = \$334.75	
23190	4:21 HOURS TO 4:30 HOURS (23 basic units) Fee: \$411.70 Benefit: 75% = \$308.80 85% = \$349.95	
23200	4:31 HOURS TO 4:40 HOURS (24 basic units) Fee: \$429.60 Benefit: 75% = \$322.20 85% = \$365.20	
23210	4:41 HOURS TO 4:50 HOURS (25 basic units) Fee: \$447.50 Benefit: 75% = \$335.65 85% = \$382.30	
23220	4:51 HOURS TO 5:00 HOURS (26 basic units) Fee: \$465.40 Benefit: 75% = \$349.05 85% = \$400.20	
23230	5:01 HOURS TO 5:10 HOURS (27 basic units) Fee: \$483.30 Benefit: 75% = \$362.50 85% = \$418.10	
23240	5:11 HOURS TO 5:20 HOURS (28 basic units) Fee: \$501.20 Benefit: 75% = \$375.90 85% = \$436.00	
23250	5:21 HOURS TO 5:30 HOURS (29 basic units) Fee: \$519.10 Benefit: 75% = \$389.35 85% = \$453.90	
23260	5:31 HOURS TO 5:40 HOURS (30 basic units) Fee: \$537.00 Benefit: 75% = \$402.75 85% = \$471.80	
23270	5:41 HOURS TO 5:50 HOURS (31 basic units) Fee: \$554.90 Benefit: 75% = \$416.20 85% = \$489.70	
23280	(5:51 HOURS TO 6:00 HOURS (32 basic units) Fee: \$572.80 Benefit: 75% = \$429.60 85% = \$507.60	
23290	6:01 HOURS TO 6:10 HOURS (33 basic units) Fee: \$590.70 Benefit: 75% = \$443.05 85% = \$525.50	
23300	6:11 HOURS TO 6:20 HOURS (34 basic units) Fee: \$608.60 Benefit: 75% = \$456.45 85% = \$543.40	
23310	6:21 HOURS TO 6:30 HOURS (35 basic units) Fee: \$626.50 Benefit: 75% = \$469.90 85% = \$561.30	
23320	6:31 HOURS TO 6:40 HOURS (36 basic units) Fee: \$644.40 Benefit: 75% = \$483.30 85% = \$579.20	
23330	6:41 HOURS TO 6:50 HOURS (37 basic units) Fee: \$662.30 Benefit: 75% = \$496.75 85% = \$597.10	
23340	6:51 HOURS TO 7:00 HOURS (38 basic units) Fee: \$680.20 Benefit: 75% = \$510.15 85% = \$615.00	
23350	7:01 HOURS TO 7:10 HOURS (39 basic units) Fee: \$698.10 Benefit: 75% = \$523.60 85% = \$632.90	
23360	7:11 HOURS TO 7:20 HOURS (40 basic units) Fee: \$716.00 Benefit: 75% = \$537.00 85% = \$650.80	
23370	7:21 HOURS TO 7:30 HOURS (41 basic units) Fee: \$733.90 Benefit: 75% = \$550.45 85% = \$668.70	
23380	7:31 HOURS TO 7:40 HOURS (42 basic units) Fee: \$751.80 Benefit: 75% = \$563.85 85% = \$686.60	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
23390	7:41 HOURS TO 7:50 HOURS (43 basic units) Fee: \$769.70 Benefit: 75% = \$577.30 85% = \$704.50	
23400	7:51 HOURS TO 8:00 HOURS (44 basic units) Fee: \$787.60 Benefit: 75% = \$590.70 85% = \$722.40	
23410	8:01 HOURS TO 8:10 HOURS (45 basic units) Fee: \$805.50 Benefit: 75% = \$604.15 85% = \$740.30	
23420	8:11 HOURS TO 8:20 HOURS (46 basic units) Fee: \$823.40 Benefit: 75% = \$617.55 85% = \$758.20	
23430	8:21 HOURS TO 8:30 HOURS (47 basic units) Fee: \$841.30 Benefit: 75% = \$631.00 85% = \$776.10	
23440	8:31 HOURS TO 8:40 HOURS (48 basic units) Fee: \$859.20 Benefit: 75% = \$644.40 85% = \$794.00	
23450	8:41 HOURS TO 8:50 HOURS (49 basic units) Fee: \$877.10 Benefit: 75% = \$657.85 85% = \$811.90	
23460	8:51 HOURS TO 9:00 HOURS (50 basic units) Fee: \$895.00 Benefit: 75% = \$671.25 85% = \$829.80	
23470	9:01 HOURS TO 9:10 HOURS (51 basic units) Fee: \$912.90 Benefit: 75% = \$684.70 85% = \$847.70	
23480	9:11 HOURS TO 9:20 HOURS (52 basic units) Fee: \$930.80 Benefit: 75% = \$698.10 85% = \$865.60	
23490	9:21 HOURS TO 9:30 HOURS (53 basic units) Fee: \$948.70 Benefit: 75% = \$711.55 85% = \$883.50	
23500	9:31 HOURS TO 9:40 HOURS (54 basic units) Fee: \$966.60 Benefit: 75% = \$724.95 85% = \$901.40	
23510	9:41 HOURS TO 9:50 HOURS (55 basic units) Fee: \$984.50 Benefit: 75% = \$738.40 85% = \$919.30	
23520	9:51 HOURS TO 10:00 HOURS (56 basic units) Fee: \$1,002.40 Benefit: 75% = \$751.80 85% = \$937.20	
23530	10:01 HOURS TO 10:10 HOURS (57 basic units) Fee: \$1,020.30 Benefit: 75% = \$765.25 85% = \$955.10	
23540	10:11 HOURS TO 10:20 HOURS (58 basic units) Fee: \$1,038.20 Benefit: 75% = \$778.65 85% = \$973.00	
23550	10:21 HOURS TO 10:30 HOURS (59 basic units) Fee: \$1,056.10 Benefit: 75% = \$792.10 85% = \$990.90	
23560	10:31 HOURS TO 10:40 HOURS (60 basic units) Fee: \$1,074.00 Benefit: 75% = \$805.50 85% = \$1,008.80	
23570	10:41 HOURS TO 10:50 HOURS (61 basic units) Fee: \$1,091.90 Benefit: 75% = \$818.95 85% = \$1,026.70	
23580	10:51 HOURS TO 11:00 HOURS (62 basic units) Fee: \$1,109.80 Benefit: 75% = \$832.35 85% = \$1,044.60	
23590	11:01 HOURS TO 11:10 HOURS (63 basic units) Fee: \$1,127.70 Benefit: 75% = \$845.80 85% = \$1,062.50	
23600	11:11 HOURS TO 11:20 HOURS (64 basic units) Fee: \$1,145.60 Benefit: 75% = \$859.20 85% = \$1,080.40	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
23610	11:21 HOURS TO 11:30 HOURS (65 basic units) Fee: \$1,163.50 Benefit: 75% = \$872.65 85% = \$1,098.30	
23620	11:31 HOURS TO 11:40 HOURS (66 basic units) Fee: \$1,181.40 Benefit: 75% = \$886.05 85% = \$1,116.20	
23630	11:41 HOURS TO 11:50 HOURS (67 basic units) Fee: \$1,199.30 Benefit: 75% = \$899.50 85% = \$1,134.10	
23640	11:51 HOURS TO 12:00 HOURS (68 basic units) Fee: \$1,217.20 Benefit: 75% = \$912.90 85% = \$1,152.00	
23650	12:01 HOURS TO 12:10 HOURS (69 basic units) Fee: \$1,235.10 Benefit: 75% = \$926.35 85% = \$1,169.90	
23660	12:11 HOURS TO 12:20 HOURS (70 basic units) Fee: \$1,253.00 Benefit: 75% = \$939.75 85% = \$1,187.80	
23670	12:21 HOURS TO 12:30 HOURS (71 basic units) Fee: \$1,270.90 Benefit: 75% = \$953.20 85% = \$1,205.70	
23680	12:31 HOURS TO 12:40 HOURS (72 basic units) Fee: \$1,288.80 Benefit: 75% = \$966.60 85% = \$1,223.60	
23690	12:41 HOURS TO 12:50 HOURS (73 basic units) Fee: \$1,306.70 Benefit: 75% = \$980.05 85% = \$1,241.50	
23700	12:51 HOURS TO 13:00 HOURS (74 basic units) Fee: \$1,324.60 Benefit: 75% = \$993.45 85% = \$1,259.40	
23710	13:01 HOURS TO 13:10 HOURS (75 basic units) Fee: \$1,342.50 Benefit: 75% = \$1,006.90 85% = \$1,277.30	
23720	13:11 HOURS TO 13:20 HOURS (76 basic units) Fee: \$1,360.40 Benefit: 75% = \$1,020.30 85% = \$1,295.20	
23730	13:21 HOURS TO 13:30 HOURS (77 basic units) Fee: \$1,378.30 Benefit: 75% = \$1,033.75 85% = \$1,313.10	
23740	13:31 HOURS TO 13:40 HOURS (78 basic units) Fee: \$1,396.20 Benefit: 75% = \$1,047.15 85% = \$1,331.00	
23750	13:41 HOURS TO 13:50 HOURS (79 basic units) Fee: \$1,414.10 Benefit: 75% = \$1,060.60 85% = \$1,348.90	
23760	13:51 HOURS TO 14:00 HOURS (80 basic units) Fee: \$1,432.00 Benefit: 75% = \$1,074.00 85% = \$1,366.80	
23770	14:01 HOURS TO 14:10 HOURS (81 basic units) Fee: \$1,449.90 Benefit: 75% = \$1,087.45 85% = \$1,384.70	
23780	14:11 HOURS TO 14:20 HOURS (82 basic units) Fee: \$1,467.80 Benefit: 75% = \$1,100.85 85% = \$1,402.60	
23790	14:21 HOURS TO 14:30 HOURS (83 basic units) Fee: \$1,485.70 Benefit: 75% = \$1,114.30 85% = \$1,420.50	
23800	14:31 HOURS TO 14:40 HOURS (84 basic units) Fee: \$1,503.60 Benefit: 75% = \$1,127.70 85% = \$1,438.40	
23810	14:41 HOURS TO 14:50 HOURS (85 basic units) Fee: \$1,521.50 Benefit: 75% = \$1,141.15 85% = \$1,456.30	
23820	14:51 HOURS TO 15:00 HOURS (86 basic units) Fee: \$1,539.40 Benefit: 75% = \$1,154.55 85% = \$1,474.20	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
23830	15:01 HOURS TO 15:10 HOURS (87 basic units) Fee: \$1,557.30 Benefit: 75% = \$1,168.00 85% = \$1,492.10	
23840	15:11 HOURS TO 15:20 HOURS (88 basic units) Fee: \$1,575.20 Benefit: 75% = \$1,181.40 85% = \$1,510.00	
23850	15:21 HOURS TO 15:30 HOURS (89 basic units) Fee: \$1,593.10 Benefit: 75% = \$1,194.85 85% = \$1,527.90	
23860	15:31 HOURS TO 15:40 HOURS (90 basic units) Fee: \$1,611.00 Benefit: 75% = \$1,208.25 85% = \$1,545.80	
23870	15:41 HOURS TO 15:50 HOURS (91 basic units) Fee: \$1,628.90 Benefit: 75% = \$1,221.70 85% = \$1,563.70	
23880	15:51 HOURS TO 16:00 HOURS (92 basic units) Fee: \$1,646.80 Benefit: 75% = \$1,235.10 85% = \$1,581.60	
23890	16:01 HOURS TO 16:10 HOURS (93 basic units) Fee: \$1,664.70 Benefit: 75% = \$1,248.55 85% = \$1,599.50	
23900	16:11 HOURS TO 16:20 HOURS (94 basic units) Fee: \$1,682.60 Benefit: 75% = \$1,261.95 85% = \$1,617.40	
23910	16:21 HOURS TO 16:30 HOURS (95 basic units) Fee: \$1,700.50 Benefit: 75% = \$1,275.40 85% = \$1,635.30	
23920	16:31 HOURS TO 16:40 HOURS (96 basic units) Fee: \$1,718.40 Benefit: 75% = \$1,288.80 85% = \$1,653.20	
23930	16:41 HOURS TO 16:50 HOURS (97 basic units) Fee: \$1,736.30 Benefit: 75% = \$1,302.25 85% = \$1,671.10	
23940	16:51 HOURS TO 17:00 HOURS (98 basic units) Fee: \$1,754.20 Benefit: 75% = \$1,315.65 85% = \$1,689.00	
23950	17:01 HOURS TO 17:10 HOURS (99 basic units) Fee: \$1,772.10 Benefit: 75% = \$1,329.10 85% = \$1,706.90	
23960	17:11 HOURS TO 17:20 HOURS (100 basic units) Fee: \$1,790.00 Benefit: 75% = \$1,342.50 85% = \$1,724.80	
23970	17:21 HOURS TO 17:30 HOURS (101 basic units) Fee: \$1,807.90 Benefit: 75% = \$1,355.95 85% = \$1,742.70	
23980	17:31 HOURS TO 17:40 HOURS (102 basic units) Fee: \$1,825.80 Benefit: 75% = \$1,369.35 85% = \$1,760.60	
23990	17:41 HOURS TO 17:50 HOURS (103 basic units) Fee: \$1,843.70 Benefit: 75% = \$1,382.80 85% = \$1,778.50	
24100	17:51 HOURS TO 18:00 HOURS (104 basic units) Fee: \$1,861.60 Benefit: 75% = \$1,396.20 85% = \$1,796.40	
24101	18:01 HOURS TO 18:10 HOURS (105 basic units) Fee: \$1,879.50 Benefit: 75% = \$1,409.65 85% = \$1,814.30	
24102	18:11 HOURS TO 18:20 HOURS (106 basic units) Fee: \$1,897.40 Benefit: 75% = \$1,423.05 85% = \$1,832.20	
24103	18:21 HOURS TO 18:30 HOURS (107 basic units) Fee: \$1,915.30 Benefit: 75% = \$1,436.50 85% = \$1,850.10	
24104	18:31 HOURS TO 18:40 HOURS (108 basic units) Fee: \$1,933.20 Benefit: 75% = \$1,449.90 85% = \$1,868.00	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
24105	18:41 HOURS TO 18:50 HOURS (109 basic units) Fee: \$1,951.10 Benefit: 75% = \$1,463.35 85% = \$1,885.90	
24106	18:51 HOURS TO 19:00 HOURS (110 basic units) Fee: \$1,969.00 Benefit: 75% = \$1,476.75 85% = \$1,903.80	
24107	19:01 HOURS TO 19:10 HOURS (111 basic units) Fee: \$1,986.90 Benefit: 75% = \$1,490.20 85% = \$1,921.70	
24108	19:11 HOURS TO 19:20 HOURS (112 basic units) Fee: \$2,004.80 Benefit: 75% = \$1,503.60 85% = \$1,939.60	
24109	19:21 HOURS TO 19:30 HOURS (113 basic units) Fee: \$2,022.70 Benefit: 75% = \$1,517.05 85% = \$1,957.50	
24110	19:31 HOURS TO 19:40 HOURS (114 basic units) Fee: \$2,040.60 Benefit: 75% = \$1,530.45 85% = \$1,975.40	
24111	19:41 HOURS TO 19:50 HOURS (115 basic units) Fee: \$2,058.50 Benefit: 75% = \$1,543.90 85% = \$1,993.30	
24112	19:51 HOURS TO 20:00 HOURS (116 basic units) Fee: \$2,076.40 Benefit: 75% = \$1,557.30 85% = \$2,011.20	
24113	20:01 HOURS TO 20:10 HOURS (117 basic units) Fee: \$2,094.30 Benefit: 75% = \$1,570.75 85% = \$2,029.10	
24114	20:11 HOURS TO 20:20 HOURS (118 basic units) Fee: \$2,112.20 Benefit: 75% = \$1,584.15 85% = \$2,047.00	
24115	20:21 HOURS TO 20:30 HOURS (119 basic units) Fee: \$2,130.10 Benefit: 75% = \$1,597.60 85% = \$2,064.90	
24116	20:31 HOURS TO 20:40 HOURS (120 basic units) Fee: \$2,148.00 Benefit: 75% = \$1,611.00 85% = \$2,082.80	
24117	20:41 HOURS TO 20:50 HOURS (121 basic units) Fee: \$2,165.90 Benefit: 75% = \$1,624.45 85% = \$2,100.70	
24118	20:51 HOURS TO 21:00 HOURS (122 basic units) Fee: \$2,183.80 Benefit: 75% = \$1,637.85 85% = \$2,118.60	
24119	21:01 HOURS TO 21:10 HOURS (123 basic units) Fee: \$2,201.70 Benefit: 75% = \$1,651.30 85% = \$2,136.50	
24120	21:11 HOURS TO 21:20 HOURS (124 basic units) Fee: \$2,219.60 Benefit: 75% = \$1,664.70 85% = \$2,154.40	
24121	21:21 HOURS TO 21:30 HOURS (125 basic units) Fee: \$2,237.50 Benefit: 75% = \$1,678.15 85% = \$2,172.30	
24122	21:31 HOURS TO 21:40 HOURS (126 basic units) Fee: \$2,255.40 Benefit: 75% = \$1,691.55 85% = \$2,190.20	
24123	21:41 HOURS TO 21:50 HOURS (127 basic units) Fee: \$2,273.30 Benefit: 75% = \$1,705.00 85% = \$2,208.10	
24124	21:51 HOURS TO 22:00 HOURS (128 basic units) Fee: \$2,291.20 Benefit: 75% = \$1,718.40 85% = \$2,226.00	
24125	22:01 HOURS TO 22:10 HOURS (129 basic units) Fee: \$2,309.10 Benefit: 75% = \$1,731.85 85% = \$2,243.90	
24126	22:11 HOURS TO 22:20 HOURS (130 basic units) Fee: \$2,327.00 Benefit: 75% = \$1,745.25 85% = \$2,261.80	

RELATIVE VALUE GUIDE		ANAESTHESIA MODIFYING UNITS	
24127	22:21 HOURS TO 22:30 HOURS (131 basic units) Fee: \$2,344.90 Benefit: 75% = \$1,758.70 85% = \$2,279.70		
24128	22:31 HOURS TO 22:40 HOURS (132 basic units) Fee: \$2,362.80 Benefit: 75% = \$1,772.10 85% = \$2,297.60		
24129	22:41 HOURS TO 22:50 HOURS (133 basic units) Fee: \$2,380.70 Benefit: 75% = \$1,785.55 85% = \$2,315.50		
24130	22:51 HOURS TO 23:00 HOURS (134 basic units) Fee: \$2,398.60 Benefit: 75% = \$1,798.95 85% = \$2,333.40		
24131	23:01 HOURS TO 23:10 HOURS (135 basic units) Fee: \$2,416.50 Benefit: 75% = \$1,812.40 85% = \$2,351.30		
24132	23:11 HOURS TO 23:20 HOURS (136 basic units) Fee: \$2,434.40 Benefit: 75% = \$1,825.80 85% = \$2,369.20		
24133	23:21 HOURS TO 23:30 HOURS (137 basic units) Fee: \$2,452.30 Benefit: 75% = \$1,839.25 85% = \$2,387.10		
24134	23:31 HOURS TO 23:40 HOURS (138 basic units) Fee: \$2,470.20 Benefit: 75% = \$1,852.65 85% = \$2,405.00		
24135	23:41 HOURS TO 23:50 HOURS (139 basic units) Fee: \$2,488.10 Benefit: 75% = \$1,866.10 85% = \$2,422.90		
24136	23:51 HOURS TO 24:00 HOURS (140 basic units) Fee: \$2,506.00 Benefit: 75% = \$1,879.50 85% = \$2,440.80		
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: \$17.90 Benefit: 75% = \$13.45 85% = \$15.25		
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: \$35.80 Benefit: 75% = \$26.85 85% = \$30.45		
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: \$53.70 Benefit: 75% = \$40.30 85% = \$45.65		
SUBGROUP 23 - ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER			
25015	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient is less than 12 months of age or 70 years or greater (1 basic units) Fee: \$17.90 Benefit: 75% = \$13.45 85% = \$15.25		
25020	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units) (See para T10.3 of explanatory notes to this Category) Fee: \$35.80 Benefit: 75% = \$26.85 85% = \$30.45		

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 diagnostics 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 diagnostics 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 \$89.50 (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 \$89.50 (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	<p>OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds (See para T8.9 of explanatory notes to this Category)</p> <p>Derived Fee: 50% of the fee which would have applied had the procedure not been discontinued</p>
30003	<p>LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation</p> <p>Fee: \$32.80 Benefit: 75% = \$24.60 85% = \$27.90</p>
30006	<p>EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation</p> <p>Fee: \$42.00 Benefit: 75% = \$31.50 85% = \$35.70</p>
30009 G 30010 S	<p>LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)</p> <p>Fee: \$54.85 Benefit: 75% = \$41.15</p> <p>Fee: \$66.75 Benefit: 75% = \$50.10</p>
30013 G 30014 S	<p>EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)</p> <p>Fee: \$118.20 Benefit: 75% = \$88.65</p> <p>Fee: \$140.30 Benefit: 75% = \$105.25</p>
30017	<p>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.)</p> <p>Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30</p>
30020	<p>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.)</p> <p>Fee: \$573.45 Benefit: 75% = \$430.10</p>
30023	<p>WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) (See para T8.10 of explanatory notes to this Category)</p> <p>Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30</p>
30024	<p>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.)</p> <p>Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30</p>
30026	<p>SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) (See para T8.10 of explanatory notes to this Category)</p> <p>Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10</p>
30029	<p>SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) (See para T8.10 of explanatory notes to this Category)</p> <p>Fee: \$81.25 Benefit: 75% = \$60.95 85% = \$69.10</p>
30032	<p>SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) (See para T8.10 of explanatory notes to this Category)</p> <p>Fee: \$74.50 Benefit: 75% = \$55.90 85% = \$63.35</p>
30035	<p>SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) (See para T8.10 of explanatory notes to this Category)</p> <p>Fee: \$106.15 Benefit: 75% = \$79.65 85% = \$90.25</p>

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: \$81.25	Benefit: 75% = \$60.95 85% = \$69.10
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: \$130.05	Benefit: 75% = \$97.55 85% = \$110.55
		Fee: \$167.65	Benefit: 75% = \$125.75 85% = \$142.55
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: \$106.15	Benefit: 75% = \$79.65 85% = \$90.25
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: \$135.20	Benefit: 75% = \$101.40 85% = \$114.95
		Fee: \$167.65	Benefit: 75% = \$125.75 85% = \$142.55
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	Fee: \$229.35	Benefit: 75% = \$172.05 85% = \$194.95
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: \$66.75	Benefit: 75% = \$50.10 85% = \$56.75
+ 30058	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.)	Fee: \$130.35	Benefit: 75% = \$97.80 85% = \$110.80
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.)	Fee: \$21.20	Benefit: 75% = \$15.90 85% = \$18.05
† 30062	Etonogestral subcutaneous implant, removal of, as an independent procedure (Anaes.)	Fee: \$54.85	Benefit: 75% = \$41.15 85% = \$46.65
30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)	Fee: \$99.25	Benefit: 75% = \$74.45 85% = \$84.40
30067 G 30068 S	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.)	Fee: \$201.95	Benefit: 75% = \$151.50 85% = \$171.70
		Fee: \$249.95	Benefit: 75% = \$187.50 85% = \$212.50
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: \$47.15	Benefit: 75% = \$35.40 85% = \$40.10
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: \$106.15	Benefit: 75% = \$79.65 85% = \$90.25
		Fee: \$135.20	Benefit: 75% = \$101.40 85% = \$114.95
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: \$43.75	Benefit: 75% = \$32.85 85% = \$37.20

OPERATIONS		GENERAL
30081	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.) <i>(See para T8.11 of explanatory notes to this Category)</i> Fee: \$99.25 Benefit: 75% = \$74.45 85% = \$84.40	
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: \$53.10 Benefit: 75% = \$39.85 85% = \$45.15	
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: \$26.60 Benefit: 75% = \$19.95 85% = \$22.65	
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: \$116.10 Benefit: 75% = \$87.10 85% = \$98.70	
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: \$154.95 Benefit: 75% = \$116.25 85% = \$131.75	
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: \$171.05 Benefit: 75% = \$128.30 85% = \$145.40	
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: \$166.05 Benefit: 75% = \$124.55 85% = \$141.15	
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: \$87.80 Benefit: 75% = \$65.85 85% = \$74.65	
30099	SINUS, excision of, involving superficial tissue only (Anaes.) Fee: \$81.25 Benefit: 75% = \$60.95 85% = \$69.10	
30102 G 30103 S	SINUS, excision of, involving muscle and deep tissue (Anaes.) Fee: \$135.20 Benefit: 75% = \$101.40 85% = \$114.95 Fee: \$166.05 Benefit: 75% = \$124.55 85% = \$141.15	
30104	PRE-AURICULAR SINUS, excision of (Anaes.) Fee: \$114.60 Benefit: 75% = \$85.95 85% = \$97.45	
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: \$140.30 Benefit: 75% = \$105.25 85% = \$119.30 Fee: \$198.65 Benefit: 75% = \$149.00 85% = \$168.90	
30110 G 30111 S	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.) (Assist.) Fee: \$256.80 Benefit: 75% = \$192.60 85% = \$218.30 Fee: \$335.50 Benefit: 75% = \$251.65 85% = \$285.20	
30114	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.) Fee: \$335.50 Benefit: 75% = \$251.65	
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: \$410.75 Benefit: 75% = \$308.10 85% = \$349.15	

OPERATIONS		GENERAL
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.) (See para T8.12 of explanatory notes to this Category) Fee: \$410.75 Benefit: 75% = \$308.10 85% = \$349.15	
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.) (See para T8.12 of explanatory notes to this Category) Fee: \$624.75 Benefit: 75% = \$468.60 85% = \$559.55	
30174	LIPECTOMY subumbilical excision with undermining of skin edges and strengthening of musculoaponeurotic wall, not being a service associated with items 45564 or 45565 or 45530 (Anaes.) (Assist.) (See para T8.12 of explanatory notes to this Category) Fee: \$624.75 Benefit: 75% = \$468.60 85% = \$559.55	
30177	LIPECTOMY radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (Anaes.) (Assist.) (See para T8.12 of explanatory notes to this Category) Fee: \$890.20 Benefit: 75% = \$667.65	
30180	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.) Fee: \$123.25 Benefit: 75% = \$92.45 85% = \$104.80	
30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.) Fee: \$222.60 Benefit: 75% = \$166.95 85% = \$189.25	
30185	PALMAR OR PLANTAR WARTS (10 or more), definitive removal of, excluding ablative methods alone, not being a service to which item 30186 or 30187 applies (Anaes.) (See para T8.13 of explanatory notes to this Category) Fee: \$164.80 Benefit: 75% = \$123.60 85% = \$140.10	
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.) (See para T8.13 of explanatory notes to this Category) Fee: \$42.85 Benefit: 75% = \$32.15 85% = \$36.45	
30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.) (See para T8.13 of explanatory notes to this Category) Fee: \$232.05 Benefit: 75% = \$174.05 85% = \$197.25	
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, not being a service associated with a service to which another item in this Group applies (Anaes.) (See para T8.13 of explanatory notes to this Category) Fee: \$133.00 Benefit: 75% = \$99.75 85% = \$113.05	
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: \$359.25 Benefit: 75% = \$269.45 85% = \$305.40	
30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) (See para T8.13 of explanatory notes to this Category) Fee: \$35.75 Benefit: 75% = \$26.85 85% = \$30.40	
30195	BENIGN NEOPLASM OF SKIN, other than viral verrucae (common warts) seborrheic keratoses, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (1 or more lesions) (Anaes.) (See para T8.13 of explanatory notes to this Category) Fee: \$57.35 Benefit: 75% = \$43.05 85% = \$48.75	

OPERATIONS	GENERAL
30196	<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 or erbium laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes.) (See para T8.14 of explanatory notes to this Category)</p> <p>Fee: \$114.05 Benefit: 75% = \$85.55 85% = \$96.95</p>
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.) (See para T8.14 of explanatory notes to this Category)</p> <p>Fee: \$397.40 Benefit: 75% = \$298.05 85% = \$337.80</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 (See para T8.14 of explanatory notes to this Category)</p> <p>Fee: \$43.65 Benefit: 75% = \$32.75 85% = \$37.15</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) (See para T8.14 of explanatory notes to this Category)</p> <p>Fee: \$153.75 Benefit: 75% = \$115.35 85% = \$130.70</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.)</p> <p>Fee: \$114.05 Benefit: 75% = \$85.55 85% = \$96.95</p>
30207	<p>SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (Anaes.)</p> <p>Fee: \$40.25 Benefit: 75% = \$30.20 85% = \$34.25</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 (Anaes.)</p> <p>Fee: \$147.15 Benefit: 75% = \$110.40 85% = \$125.10</p>
30213	<p>TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes.) (See para T8.15 of explanatory notes to this Category)</p> <p>Fee: \$99.15 Benefit: 75% = \$74.40 85% = \$84.30</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 - <i>where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period</i> (See para T8.15 of explanatory notes to this Category)</p> <p>Fee: \$99.15 Benefit: 75% = \$74.40 85% = \$84.30</p>
30216	<p>HAEMATOMA, aspiration of (Anaes.)</p> <p>Fee: \$24.70 Benefit: 75% = \$18.55 85% = \$21.00</p>
30219	<p>HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)</p> <p>Fee: \$24.70 Benefit: 75% = \$18.55 85% = \$21.00</p>
30223	<p>LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.)</p> <p>Fee: \$147.15 Benefit: 75% = \$110.40</p>
30224	<p>PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.)</p> <p>Fee: \$214.55 Benefit: 75% = \$160.95 85% = \$182.40</p>
30225	<p>ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.)</p> <p>Fee: \$241.70 Benefit: 75% = \$181.30 85% = \$205.45</p>
30226	<p>MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.)</p> <p>Fee: \$135.20 Benefit: 75% = \$101.40 85% = \$114.95</p>

OPERATIONS		GENERAL
30229	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.) Fee: \$246.50 Benefit: 75% = \$184.90 85% = \$209.55	
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) Fee: \$201.95 Benefit: 75% = \$151.50 85% = \$171.70	
30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) Fee: \$267.00 Benefit: 75% = \$200.25 85% = \$226.95	
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) Fee: \$135.20 Benefit: 75% = \$101.40 85% = \$114.95	
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$321.85 Benefit: 75% = \$241.40 85% = \$273.60	
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) Fee: \$321.85 Benefit: 75% = \$241.40	
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) Fee: \$622.95 Benefit: 75% = \$467.25	
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.) Fee: \$667.65 Benefit: 75% = \$500.75	
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.) Fee: \$1,129.80 Benefit: 75% = \$847.35	
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.) Fee: \$1,735.45 Benefit: 75% = \$1,301.60 85% = \$1,670.25	
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.) Fee: \$753.25 Benefit: 75% = \$564.95	
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) Fee: \$1,003.05 Benefit: 75% = \$752.30	
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) Fee: \$402.25 Benefit: 75% = \$301.70	
+ 30259	SUBLINGUAL GLAND, extirpation of (Anaes.) Fee: \$179.30 Benefit: 75% = \$134.50 85% = \$152.45	
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) Fee: \$53.10 Benefit: 75% = \$39.85 85% = \$45.15	
30265 G 30266 S	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) Fee: \$106.15 Benefit: 75% = \$79.65 85% = \$90.25 Fee: \$135.20 Benefit: 75% = \$101.40 85% = \$114.95	
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) Fee: \$135.20 Benefit: 75% = \$101.40 85% = \$114.95	
30272	TONGUE, partial excision of (Anaes.) (Assist.) Fee: \$267.00 Benefit: 75% = \$200.25 85% = \$226.95	
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commandotype operation) (Anaes.) (Assist.) Fee: \$1,591.95 Benefit: 75% = \$1,194.00	
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes.) Fee: \$42.00 Benefit: 75% = \$31.50 85% = \$35.70	
30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.) Fee: \$107.85 Benefit: 75% = \$80.90 85% = \$91.70	

OPERATIONS		GENERAL	
30282 G 30283 S	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) Fee: \$140.30 Fee: \$184.85	Benefit: 75% = \$105.25 Benefit: 75% = \$138.65	85% = \$119.30 85% = \$157.15
30286	BRANCHIAL CYST, removal of (Anaes.) (Assist.) Fee: \$359.35	Benefit: 75% = \$269.55	85% = \$305.45
30289	BRANCHIAL FISTULA, removal of (Anaes.) (Assist.) Fee: \$453.60	Benefit: 75% = \$340.20	
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.) Fee: \$402.25	Benefit: 75% = \$301.70	85% = \$341.95
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) Fee: \$1,591.95	Benefit: 75% = \$1,194.00	
30296	THYROIDECTOMY, total (Anaes.) (Assist.) Fee: \$924.50	Benefit: 75% = \$693.40	
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) Fee: \$924.50	Benefit: 75% = \$693.40	
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: \$575.65	Benefit: 75% = \$431.75	
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: \$690.80	Benefit: 75% = \$518.10	
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: \$460.50	Benefit: 75% = \$345.40	
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: \$552.60	Benefit: 75% = \$414.45	
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) Fee: \$721.25	Benefit: 75% = \$540.95	
30308	BILATERAL SUBTOTAL THYROIDECTOMY (Anaes.) (Assist.) Fee: \$721.25	Benefit: 75% = \$540.95	
30309	THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (Anaes.) (Assist.) Fee: \$924.50	Benefit: 75% = \$693.40	
30310	THYROID, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Anaes.) (Assist.) Fee: \$413.05	Benefit: 75% = \$309.80	
30313	THYROGLOSSAL CYST, removal of (Anaes.) (Assist.) Fee: \$246.50	Benefit: 75% = \$184.90	85% = \$209.55
30314	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) Fee: \$413.05	Benefit: 75% = \$309.80	

OPERATIONS	GENERAL
30315	PARATHYROID operation for hyperparathyroidism (Anaes.) (Assist.) Fee: \$1,029.40 Benefit: 75% = \$772.05
30317	CERVICAL REEXPLORATION for recurrent or persistent hyperparathyroidism (Anaes.) (Assist.) Fee: \$1,232.65 Benefit: 75% = \$924.50
30318	MEDIASTINUM, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) Fee: \$819.65 Benefit: 75% = \$614.75
30320	MEDIASTINUM, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) Fee: \$1,232.65 Benefit: 75% = \$924.50
30321	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of (Anaes.) (Assist.) Fee: \$819.65 Benefit: 75% = \$614.75
30323	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of, requiring complex and extensive dissection (Anaes.) (Assist.) Fee: \$1,232.65 Benefit: 75% = \$924.50
30324	ADRENAL GLAND TUMOUR, excision of (Anaes.) (Assist.) Fee: \$1,232.65 Benefit: 75% = \$924.50
30329	LYMPH GLANDS of GROIN, limited excision of (Anaes.) Fee: \$223.00 Benefit: 75% = \$167.25 85% = \$189.55
30330	LYMPH GLANDS of GROIN, radical excision of (Anaes.) (Assist.) Fee: \$649.05 Benefit: 75% = \$486.80
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.) Fee: \$313.20 Benefit: 75% = \$234.90
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: \$782.85 Benefit: 75% = \$587.15
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: \$939.45 Benefit: 75% = \$704.60
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) Fee: \$436.45 Benefit: 75% = \$327.35
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: \$470.70 Benefit: 75% = \$353.05
30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05
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: \$472.90 Benefit: 75% = \$354.70
30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.) Fee: \$838.20 Benefit: 75% = \$628.65
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.) Fee: \$1,180.25 Benefit: 75% = \$885.20
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.) Fee: \$992.85 Benefit: 75% = \$744.65

OPERATIONS		GENERAL
30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.) Fee: \$508.70 Benefit: 75% = \$381.55	
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: \$573.45 Benefit: 75% = \$430.10	
30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.) Fee: \$1,442.65 Benefit: 75% = \$1,082.00	
30390	LAPAROSCOPY, diagnostic (Anaes.) Fee: \$198.65 Benefit: 75% = \$149.00	
30391	LAPAROSCOPY with biopsy (Anaes.) (Assist.) Fee: \$256.80 Benefit: 75% = \$192.60	
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) Fee: \$609.10 Benefit: 75% = \$456.85	
30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) Fee: \$472.90 Benefit: 75% = \$354.70	
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: \$445.05 Benefit: 75% = \$333.80	
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: \$918.05 Benefit: 75% = \$688.55	
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: \$209.80 Benefit: 75% = \$157.35	
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: \$288.60 Benefit: 75% = \$216.45	
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) Fee: \$571.20 Benefit: 75% = \$428.40	
30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.) Fee: \$419.60 Benefit: 75% = \$314.70	
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05	
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: \$826.30 Benefit: 75% = \$619.75	
30406	PARACENTESIS ABDOMINIS (Anaes.) Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10	
30408	PERITONEO venous (Leveen) shunt, insertion of (Anaes.) (Assist.) Fee: \$354.10 Benefit: 75% = \$265.60	
30409	LIVER BIOPSY, percutaneous (Anaes.) Fee: \$157.60 Benefit: 75% = \$118.20 85% = \$134.00	

OPERATIONS		GENERAL
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) Fee: \$80.20 Benefit: 75% = \$60.15	
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) Fee: \$47.25 Benefit: 75% = \$35.45 85% = \$40.20	
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) Fee: \$622.95 Benefit: 75% = \$467.25	
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) Fee: \$1,245.85 Benefit: 75% = \$934.40	
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.) Fee: \$676.40 Benefit: 75% = \$507.30	
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.) Fee: \$1,014.55 Benefit: 75% = \$760.95	
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) Fee: \$1,442.65 Benefit: 75% = \$1,082.00	
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: \$737.95 Benefit: 75% = \$553.50 85% = \$672.75	
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.) (Assist.) Fee: \$1,803.10 Benefit: 75% = \$1,352.35	
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) Fee: \$609.85 Benefit: 75% = \$457.40	
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) Fee: \$1,180.25 Benefit: 75% = \$885.20	
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) Fee: \$1,409.70 Benefit: 75% = \$1,057.30	
30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.) Fee: \$1,508.10 Benefit: 75% = \$1,131.10 85% = \$1,442.90	
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.) Fee: \$2,098.20 Benefit: 75% = \$1,573.65 85% = \$2,033.00	
30431	LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05 85% = \$405.50	
30433	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.) Fee: \$655.65 Benefit: 75% = \$491.75	
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.) Fee: \$531.20 Benefit: 75% = \$398.40	
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: \$590.15 Benefit: 75% = \$442.65	
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.) Fee: \$734.45 Benefit: 75% = \$550.85	
30438	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.) Fee: \$1,039.30 Benefit: 75% = \$779.50 85% = \$974.10	
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: \$167.65 Benefit: 75% = \$125.75	

OPERATIONS		GENERAL
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: \$475.35 Benefit: 75% = \$356.55 85% = \$410.15	
30441	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.) Fee: \$123.05 Benefit: 75% = \$92.30	
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.) Fee: \$167.65 Benefit: 75% = \$125.75	
30443	CHOLECYSTECTOMY (Anaes.) (Assist.) Fee: \$667.65 Benefit: 75% = \$500.75	
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.) Fee: \$667.65 Benefit: 75% = \$500.75	
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.) Fee: \$667.65 Benefit: 75% = \$500.75	
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.) Fee: \$878.65 Benefit: 75% = \$659.00	
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.) Fee: \$977.05 Benefit: 75% = \$732.80	
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: \$473.55 Benefit: 75% = \$355.20 85% = \$408.35	
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: \$241.70 Benefit: 75% = \$181.30 85% = \$205.45	
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) Fee: \$340.95 Benefit: 75% = \$255.75	
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.) Fee: \$778.90 Benefit: 75% = \$584.20	
30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.) Fee: \$915.80 Benefit: 75% = \$686.85	
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.) Fee: \$1,245.85 Benefit: 75% = \$934.40 85% = \$1,180.65	
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: \$915.80 Benefit: 75% = \$686.85	
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) Fee: \$778.90 Benefit: 75% = \$584.20	
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: \$1,335.15 Benefit: 75% = \$1,001.40	
30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.) Fee: \$1,639.25 Benefit: 75% = \$1,229.45	
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: \$1,967.15 Benefit: 75% = \$1,475.40	

OPERATIONS		GENERAL
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) Fee: \$1,134.35 Benefit: 75% = \$850.80	
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) Fee: \$1,403.15 Benefit: 75% = \$1,052.40	
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) Fee: \$1,554.10 Benefit: 75% = \$1,165.60 85% = \$1,488.90	
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: \$839.25 Benefit: 75% = \$629.45 85% = \$774.05	
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: \$159.95 Benefit: 75% = \$120.00 85% = \$136.00	
30475	ENDOSCOPY with balloon dilatation of gastric or gastroduodenal stricture (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$289.25 Benefit: 75% = \$216.95 85% = \$245.90	
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: \$221.75 Benefit: 75% = \$166.35 85% = \$188.50	
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: \$221.75 Benefit: 75% = \$166.35 85% = \$188.50	
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: \$429.95 Benefit: 75% = \$322.50 85% = \$365.50	
30481	PERCUTANEOUS GASTROSTOMY (initial procedure), including any associated imaging services (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$322.45 Benefit: 75% = \$241.85 85% = \$274.10	
30482	PERCUTANEOUS GASTROSTOMY (repeat procedure), including any associated imaging services (Anaes.) Fee: \$229.25 Benefit: 75% = \$171.95 85% = \$194.90	
30483	GASTROSTOMY BUTTON, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes.) Fee: \$159.90 Benefit: 75% = \$119.95 85% = \$135.95	
30484	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$329.55 Benefit: 75% = \$247.20 85% = \$280.15	
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: \$508.70 Benefit: 75% = \$381.55 85% = \$443.50	
30487	SMALL BOWEL INTUBATION with biopsy (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$163.35 Benefit: 75% = \$122.55 85% = \$138.85	
30488	SMALL BOWEL INTUBATION as an independent procedure (Anaes.) Fee: \$81.25 Benefit: 75% = \$60.95 85% = \$69.10	

OPERATIONS		GENERAL
30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$475.35 Benefit: 75% = \$356.55 85% = \$410.15	
30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$501.50 Benefit: 75% = \$376.15 85% = \$436.30	
30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$710.95 Benefit: 75% = \$533.25	
30493	BILIARY MANOMETRY (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$300.95 Benefit: 75% = \$225.75 85% = \$255.85	
30494	ENDOSCOPIC BILIARY DILATATION (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$379.70 Benefit: 75% = \$284.80	
30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$710.95 Benefit: 75% = \$533.25	
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.) Fee: \$531.20 Benefit: 75% = \$398.40 85% = \$466.00	
30497	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.) Fee: \$633.30 Benefit: 75% = \$475.00	
30499	VAGOTOMY, highly selective (Anaes.) (Assist.) Fee: \$753.25 Benefit: 75% = \$564.95	
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.) Fee: \$806.50 Benefit: 75% = \$604.90 85% = \$741.30	
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.) Fee: \$890.20 Benefit: 75% = \$667.65	
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.) Fee: \$996.75 Benefit: 75% = \$747.60 85% = \$931.55	
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.) Fee: \$498.35 Benefit: 75% = \$373.80	
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.) Fee: \$872.15 Benefit: 75% = \$654.15	
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.) Fee: \$918.05 Benefit: 75% = \$688.55	
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.) Fee: \$918.05 Benefit: 75% = \$688.55 85% = \$852.85	
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: \$767.20 Benefit: 75% = \$575.40	
30512	MORBID OBESITY, gastric bypass for, by any method including anastomosis (Anaes.) (Assist.) Fee: \$944.10 Benefit: 75% = \$708.10	

OPERATIONS	GENERAL
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: \$1,389.95 Benefit: 75% = \$1,042.50
30515	GASTROENTEROSTOMY (INCLUDING GASTRODUODENOSTOMY) OR ENTEROCOLOSTOMY OR ENTEROENTEROSTOMY (Anaes.) (Assist.) Fee: \$636.05 Benefit: 75% = \$477.05
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.) Fee: \$832.80 Benefit: 75% = \$624.60
30518	PARTIAL GASTRECTOMY (Anaes.) (Assist.) Fee: \$891.80 Benefit: 75% = \$668.85
30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.) Fee: \$609.85 Benefit: 75% = \$457.40
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) Fee: \$1,304.85 Benefit: 75% = \$978.65
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: \$1,363.75 Benefit: 75% = \$1,022.85
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.) Fee: \$1,501.45 Benefit: 75% = \$1,126.10
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: \$1,947.35 Benefit: 75% = \$1,460.55
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: \$786.90 Benefit: 75% = \$590.20
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: \$1,180.25 Benefit: 75% = \$885.20
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) <i>(See para T8.23 of explanatory notes to this Category)</i> Fee: \$708.20 Benefit: 75% = \$531.15
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: \$813.15 Benefit: 75% = \$609.90
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: \$967.25 Benefit: 75% = \$725.45
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.) Fee: \$1,532.20 Benefit: 75% = \$1,149.15
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.) Fee: \$1,554.10 Benefit: 75% = \$1,165.60
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: \$1,075.40 Benefit: 75% = \$806.55

OPERATIONS	GENERAL
30539	<p>OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) Fee: \$786.90 Benefit: 75% = \$590.20</p>
30541	<p>OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.) Fee: \$1,370.45 Benefit: 75% = \$1,027.85</p>
30542	<p>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: \$931.10 Benefit: 75% = \$698.35</p>
30544	<p>OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.) Fee: \$681.95 Benefit: 75% = \$511.50</p>
30545	<p>OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.) Fee: \$1,659.05 Benefit: 75% = \$1,244.30</p>
30547	<p>OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,140.90 Benefit: 75% = \$855.70 85% = \$1,075.70</p>
30548	<p>OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) Fee: \$852.35 Benefit: 75% = \$639.30 85% = \$787.15</p>
30550	<p>OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.) (Assist.) Fee: \$1,862.30 Benefit: 75% = \$1,396.75</p>
30551	<p>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: \$1,285.20 Benefit: 75% = \$963.90</p>
30553	<p>OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) Fee: \$950.65 Benefit: 75% = \$713.00 85% = \$885.45</p>
30554	<p>OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.) Fee: \$2,072.05 Benefit: 75% = \$1,554.05</p>
30556	<p>OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,429.35 Benefit: 75% = \$1,072.05</p>
30557	<p>OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.) Fee: \$1,055.65 Benefit: 75% = \$791.75</p>
30559	<p>OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.) Fee: \$767.20 Benefit: 75% = \$575.40 85% = \$702.00</p>
30560	<p>OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.) Fee: \$852.35 Benefit: 75% = \$639.30</p>
30562	<p>ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel (Anaes.) (Assist.) Fee: \$537.35 Benefit: 75% = \$403.05</p>
30563	<p>COLOSTOMY OR ILEOSTOMY, refashioning of (Anaes.) (Assist.) Fee: \$537.35 Benefit: 75% = \$403.05 85% = \$472.15</p>
30564	<p>SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.) Fee: \$697.45 Benefit: 75% = \$523.10</p>
30565	<p>SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) Fee: \$786.90 Benefit: 75% = \$590.20</p>

OPERATIONS		GENERAL
30566	SMALL INTESTINE, resection of, with anastomosis (Anaes.) (Assist.) Fee: \$874.10 Benefit: 75% = \$655.60	
30568	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.) (Assist.) Fee: \$655.65 Benefit: 75% = \$491.75	
30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.) (Assist.) Fee: \$334.35 Benefit: 75% = \$250.80	
30571	APPENDICECTOMY, not being a service to which item 30574 applies (Anaes.) (Assist.) Fee: \$402.25 Benefit: 75% = \$301.70	
30572	LAPAROSCOPIC APPENDICECTOMY (Anaes.) (Assist.) Fee: \$402.25 Benefit: 75% = \$301.70	
30574	NOTE: <i>Multiple Operation and Multiple Anaesthetic rules apply to this item</i> APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.) Fee: \$111.35 Benefit: 75% = \$83.55	
30575	PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.) (Assist.) Fee: \$463.05 Benefit: 75% = \$347.30	
30577	PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.) Fee: \$983.60 Benefit: 75% = \$737.70	
30578	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.) Fee: \$1,036.00 Benefit: 75% = \$777.00	
30580	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.) Fee: \$944.10 Benefit: 75% = \$708.10	
30581	ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.) (Assist.) Fee: \$688.50 Benefit: 75% = \$516.40	
30583	DISTAL PANCREATECTOMY (Anaes.) (Assist.) Fee: \$1,078.50 Benefit: 75% = \$808.90	
30584	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.) Fee: \$1,591.95 Benefit: 75% = \$1,194.00	
30586	PANCREATIC CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic means (Anaes.) (Assist.) Fee: \$633.30 Benefit: 75% = \$475.00	
30587	PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.) Fee: \$655.65 Benefit: 75% = \$491.75	
30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.) Fee: \$1,129.80 Benefit: 75% = \$847.35	
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.) Fee: \$1,245.85 Benefit: 75% = \$934.40	
30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.) Fee: \$1,704.85 Benefit: 75% = \$1,278.65 85% = \$1,639.65	
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.) Fee: \$1,967.15 Benefit: 75% = \$1,475.40	
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.) Fee: \$810.35 Benefit: 75% = \$607.80	
30597	SPLENECTOMY (Anaes.) (Assist.) Fee: \$650.40 Benefit: 75% = \$487.80	

OPERATIONS		GENERAL	
30659 G 30660 S	CIRCUMCISION of a male 10 YEARS OF AGE OR OVER (Anaes.) Fee: \$135.20 Benefit: 75% = \$101.40 85% = \$114.95 Fee: \$167.65 Benefit: 75% = \$125.75 85% = \$142.55		
30663	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia (Anaes.) Fee: \$130.35 Benefit: 75% = \$97.80 85% = \$110.80		
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: \$42.85 Benefit: 75% = \$32.15 85% = \$36.45		
30672	COCCYX, excision of (Anaes.) (Assist.) Fee: \$402.25 Benefit: 75% = \$301.70		
30675 G 30676 S	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.) Fee: \$270.45 Benefit: 75% = \$202.85 85% = \$229.90 Fee: \$342.35 Benefit: 75% = \$256.80 85% = \$291.00		
30679	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.) Fee: \$86.95 Benefit: 75% = \$65.25 85% = \$73.95		
† 30680	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (oral approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) (See para T8.20 of explanatory notes to this Category) Fee: \$1,056.65 Benefit: 75% = \$792.50 85% = \$991.45		
† 30682	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (anal approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) (See para T8.20 of explanatory notes to this Category) Fee: \$1,056.65 Benefit: 75% = \$792.50 85% = \$991.45		
† 30684	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (polypectomy, snares, removal of foreign body, diathermy, heater probe or laser coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (iii) have recurrent or persistent bleeding; and (iv) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) (See para T8.20 of explanatory notes to this Category) Fee: \$1,300.30 Benefit: 75% = \$975.25 85% = \$1,235.10		

OPERATIONS	GENERAL
† 30686	<p>DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (anal approach), with or without biopsy, WITH 1 or more of the following procedures (polypectomy, snares, removal of foreign body, diathermy, heater probe or laser coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684)</p> <p>The patient to whom the service is provided must:</p> <ul style="list-style-type: none"> (v) have recurrent or persistent bleeding; and (vi) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) <p>(See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$1,300.30 Benefit: 75% = \$975.25 85% = \$1,235.10</p>
† 30688	<p>ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging)), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)</p> <p>(See para T8.20 and T8.24 of explanatory notes to this Category)</p> <p>Fee: \$329.55 Benefit: 75% = \$247.20 85% = \$280.15</p>
† 30690	<p>ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)</p> <p>(See para T8.20 and T8.24 of explanatory notes to this Category)</p> <p>Fee: \$508.70 Benefit: 75% = \$381.55 85% = \$443.50</p>
† 30692	<p>ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)</p> <p>(See para T8.20 and T8.24 of explanatory notes to this Category)</p> <p>Fee: \$329.55 Benefit: 75% = \$247.20 85% = \$280.15</p>
† 30694	<p>ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)</p> <p>(See para T8.20 and T8.24 of explanatory notes to this Category)</p> <p>Fee: \$508.70 Benefit: 75% = \$381.55 85% = \$443.50</p>
31000	<p>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.)</p> <p>Fee: \$524.55 Benefit: 75% = \$393.45 85% = \$459.35</p>
31001	<p>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.)</p> <p>Fee: \$655.65 Benefit: 75% = \$491.75 85% = \$590.45</p>
31002	<p>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.)</p> <p>Fee: \$786.90 Benefit: 75% = \$590.20 85% = \$721.70</p>
31200	<p>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</p> <p>(See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$30.70 Benefit: 75% = \$23.05 85% = \$26.10</p>
31205	<p>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), 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.)</p> <p>(See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$86.15 Benefit: 75% = \$64.65 85% = \$73.25</p>

OPERATIONS	GENERAL
31210	<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), 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.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$111.20 Benefit: 75% = \$83.40 85% = \$94.55</p>
31215	<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), 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.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$129.60 Benefit: 75% = \$97.20 85% = \$110.20</p>
31220	<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 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.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$193.75 Benefit: 75% = \$145.35 85% = \$164.70</p>
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 - <i>where the specimens excised are sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$344.35 Benefit: 75% = \$258.30 85% = \$292.70</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 - <i>where the specimen excised is sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$151.75 Benefit: 75% = \$113.85 85% = \$129.00</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 - <i>where the specimen excised is sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$129.60 Benefit: 75% = \$97.20 85% = \$110.20</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 - <i>where the specimen excised is sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$151.75 Benefit: 75% = \$113.85 85% = \$129.00</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 T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$333.20 Benefit: 75% = \$249.90 85% = \$283.25</p>
31250	<p>GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface <i>where the specimen excised is sent for histological confirmation of diagnosis</i> (Anaes.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$333.20 Benefit: 75% = \$249.90 85% = \$283.25</p>

OPERATIONS	GENERAL
31255	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from nose, eyelid, lip, ear, digit or genitalia, <u>tumour size up to and including 10mm in diameter</u> - where removal is by therapeutic surgical excision (other than by shave excision) and suture and <i>where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination</i> (Anaes.) <i>(See para T8.25 of explanatory notes to this Category)</i></p> <p>Fee: \$199.90 Benefit: 75% = \$149.95 85% = \$169.95</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, <u>where the original tumour size was up to and including 10mm in diameter</u> and where removal is by surgical excision (other than by shave excision) and suture and <i>where the specimen excised is sent for histological examination</i> (Anaes.) <i>(See para T8.25 of explanatory notes to this Category)</i></p> <p>Fee: \$199.90 Benefit: 75% = \$149.95 85% = \$169.95</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, <u>where the original tumour size was up to and including 10mm in diameter</u> and where removal is by surgical excision (other than by shave excision) and suture and <i>where the specimen excised is sent for histological examination</i> (Anaes.) <i>(See para T8.25 of explanatory notes to this Category)</i></p> <p>Fee: \$199.90 Benefit: 75% = \$149.95 85% = \$169.95</p>
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, <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 <i>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</i> (Anaes.) <i>(See para T8.25 of explanatory notes to this Category)</i></p> <p>Fee: \$199.90 Benefit: 75% = \$149.95 85% = \$169.95</p>
31260	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from nose, eyelid, lip, ear, digit or genitalia, <u>tumour size more than 10mm in diameter</u> - where removal is by therapeutic surgical excision (other than shave excision) and suture and <i>where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination</i> (Anaes.) <i>(See para T8.25 of explanatory notes to this Category)</i></p> <p>Fee: \$285.10 Benefit: 75% = \$213.85 85% = \$242.35</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, <u>where the original tumour size was more than 10mm in diameter</u> and where removal is by surgical excision (other than by shave excision) and suture and <i>where the specimen excised is sent for histological examination</i> (Anaes.) <i>(See para T8.25 of explanatory notes to this Category)</i></p> <p>Fee: \$285.10 Benefit: 75% = \$213.85 85% = \$242.35</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, <u>where the original tumour size was more than 10mm in diameter</u> and where removal is by surgical excision (other than by shave excision) and suture and <i>where the specimen excised is sent for histological examination</i> (Anaes.) <i>(See para T8.25 of explanatory notes to this Category)</i></p> <p>Fee: \$285.10 Benefit: 75% = \$213.85 85% = \$242.35</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, <u>where the tumour size is more than 10mm in diameter</u> and where removal is by surgical excision (other than by shave excision) and suture and <i>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</i> (Anaes.) <i>(See para T8.25 of explanatory notes to this Category)</i></p> <p>Fee: \$285.10 Benefit: 75% = \$213.85 85% = \$242.35</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), <u>tumour size up to and including 10mm in diameter</u> and where removal is by therapeutic surgical excision (other than by shave excision) and suture, <i>where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination</i> (Anaes.) <i>(See para T8.25 and T8.26 of explanatory notes to this Category)</i></p> <p>Fee: \$166.60 Benefit: 75% = \$124.95 85% = \$141.65</p>

OPERATIONS	GENERAL
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.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$166.60 Benefit: 75% = \$124.95 85% = \$141.65</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.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$166.60 Benefit: 75% = \$124.95 85% = \$141.65</p>
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, where the tumour size is up to and including 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained - not being a service to which item 31295 applies (Anaes.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$166.60 Benefit: 75% = \$124.95 85% = \$141.65</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.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$233.25 Benefit: 75% = \$174.95 85% = \$198.30</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.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$233.25 Benefit: 75% = \$174.95 85% = \$198.30</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.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$233.25 Benefit: 75% = \$174.95 85% = \$198.30</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, where the tumour size is more than 10mm and up to and including 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained - not being a service to which item 31295 applies (Anaes.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$233.25 Benefit: 75% = \$174.95 85% = \$198.30</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.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$270.25 Benefit: 75% = \$202.70 85% = \$229.75</p>

OPERATIONS	GENERAL
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.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$270.25 Benefit: 75% = \$202.70 85% = \$229.75</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.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$270.25 Benefit: 75% = \$202.70 85% = \$229.75</p>
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.) (See para T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$270.25 Benefit: 75% = \$202.70 85% = \$229.75</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.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$140.75 Benefit: 75% = \$105.60 85% = \$119.65</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.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$141.30 Benefit: 75% = \$106.00 85% = \$120.15</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.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$141.30 Benefit: 75% = \$106.00 85% = \$120.15</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.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$141.30 Benefit: 75% = \$106.00 85% = \$120.15</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.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$192.35 Benefit: 75% = \$144.30 85% = \$163.50</p>

OPERATIONS	GENERAL
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, <u>where the original tumour size was 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 (Anaes.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$192.35 Benefit: 75% = \$144.30 85% = \$163.50</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, <u>where the original tumour size was 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 (Anaes.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$192.35 Benefit: 75% = \$144.30 85% = \$163.50</p>
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, <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 (Anaes.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$192.35 Benefit: 75% = \$144.30 85% = \$163.50</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, <u>tumour size more than 20mm in diameter</u> 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 T8.25 of explanatory notes to this Category)</p> <p>Fee: \$222.05 Benefit: 75% = \$166.55 85% = \$188.75</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, <u>where the original tumour size was more than 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 (Anaes.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$222.05 Benefit: 75% = \$166.55 85% = \$188.75</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, <u>where the original tumour size was more than 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 (Anaes.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$222.05 Benefit: 75% = \$166.55 85% = \$188.75</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, <u>where the tumour size is more than 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 (Anaes.) (See para T8.25 of explanatory notes to this Category)</p> <p>Fee: \$222.05 Benefit: 75% = \$166.55 85% = \$188.75</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 T8.25 of explanatory notes to this Category)</p> <p>Fee: \$264.45 Benefit: 75% = \$198.35 85% = \$224.80</p>

OPERATIONS	GENERAL
‡ 31300	<p style="text-align: center;">TREATMENT OF MALIGNANT MELANOMA AND LOCALLY AGGRESSIVE SKIN TUMOURS</p> <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 that site of excision".</p> <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, <u>tumour size up to and including 10mm in diameter</u> and where removal is by definitive surgical excision (as defined above and in 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 T8.25 of explanatory notes to this Category)</p> <p>Fee: \$288.90 Benefit: 75% = \$216.70 85% = \$245.60</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, <u>tumour size more than 10mm in diameter</u> and where removal is by definitive surgical excision (as defined above and in 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 T8.25 of explanatory notes to this Category)</p> <p>Fee: \$355.40 Benefit: 75% = \$266.55 85% = \$302.10</p>
31310	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) <u>tumour size up to and including 10mm in diameter</u> and where removal is by definitive surgical excision (as defined above and in 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 T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$251.65 Benefit: 75% = \$188.75 85% = \$213.95</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 and in 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 T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$318.35 Benefit: 75% = \$238.80 85% = \$270.60</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 and in 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 T8.25 and T8.26 of explanatory notes to this Category)</p> <p>Fee: \$355.40 Benefit: 75% = \$266.55 85% = \$302.10</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 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 T8.25 of explanatory notes to this Category)</p> <p>Fee: \$244.35 Benefit: 75% = \$183.30 85% = \$207.70</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 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 T8.25 of explanatory notes to this Category)</p> <p>Fee: \$288.90 Benefit: 75% = \$216.70 85% = \$245.60</p>

OPERATIONS	GENERAL
31335	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from areas of the body not covered by items 31305 and 31320 - tumour size more than 20mm in diameter and where removal is by definitive surgical excision (as defined above and in 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 T8.25 of explanatory notes to this Category) Fee: \$333.20 Benefit: 75% = \$249.90 85% = \$283.25</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 T8.25 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 50mm or more in diameter, or is sub-fascial, where the specimen is sent for histological confirmation of diagnosis (Anaes.) (See para T8.25 of explanatory notes to this Category) Fee: \$190.45 Benefit: 75% = \$142.85 85% = \$161.90</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: \$190.45 Benefit: 75% = \$142.85 85% = \$161.90</p>
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.) (See para T8.25 of explanatory notes to this Category) Fee: \$391.35 Benefit: 75% = \$293.55 85% = \$332.65</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.) (See para T8.25 of explanatory notes to this Category) Fee: \$645.20 Benefit: 75% = \$483.90 85% = \$580.00</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: \$235.80 Benefit: 75% = \$176.85 85% = \$200.45</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: \$272.15 Benefit: 75% = \$204.15</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: \$453.50 Benefit: 75% = \$340.15 85% = \$388.30</p>
31409	<p>PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) Fee: \$1,408.95 Benefit: 75% = \$1,056.75</p>
31412	<p>RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) Fee: \$1,735.45 Benefit: 75% = \$1,301.60</p>
31420	<p>LYMPH NODE OF NECK, biopsy of (Anaes.) Fee: \$166.05 Benefit: 75% = \$124.55 85% = \$141.15</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.) (See para T8.27 of explanatory notes to this Category) Fee: \$362.75 Benefit: 75% = \$272.10 85% = \$308.35</p>

OPERATIONS	GENERAL
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 T8.27 of explanatory notes to this Category)</i> Fee: \$725.60 Benefit: 75% = \$544.20</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 T8.27 of explanatory notes to this Category)</i> Fee: \$1,130.75 Benefit: 75% = \$848.10</p>
31432	<p>LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.) <i>(See para T8.27 of explanatory notes to this Category)</i> Fee: \$1,209.40 Benefit: 75% = \$907.05</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 T8.27 of explanatory notes to this Category)</i> Fee: \$888.90 Benefit: 75% = \$666.70</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 T8.27 of explanatory notes to this Category)</i> Fee: \$1,408.95 Benefit: 75% = \$1,056.75</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: \$227.25 Benefit: 75% = \$170.45 85% = \$193.20</p>
31450	<p>LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.) Fee: \$367.25 Benefit: 75% = \$275.45</p>
31452	<p>LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.) Fee: \$642.55 Benefit: 75% = \$481.95</p>
31454	<p>LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.) Fee: \$508.70 Benefit: 75% = \$381.55</p>
31456	<p>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: \$221.75 Benefit: 75% = \$166.35</p>
31458	<p>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: \$266.15 Benefit: 75% = \$199.65</p>
31460	<p>PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) Fee: \$322.45 Benefit: 75% = \$241.85</p>
31462	<p>OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05</p>
31464	<p>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: \$786.90 Benefit: 75% = \$590.20</p>
31466	<p>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: \$1,180.30 Benefit: 75% = \$885.25</p>

OPERATIONS		GENERAL
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: \$1,296.70 Benefit: 75% = \$972.55	
31470	LAPAROSCOPIC SPLENECTOMY (Anaes.) (Assist.) Fee: \$650.40 Benefit: 75% = \$487.80	
31472	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.) Fee: \$1,056.45 Benefit: 75% = \$792.35	
31500	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.) (See para T8.28 of explanatory notes to this Category) Fee: \$234.85 Benefit: 75% = \$176.15 85% = \$199.65	
31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.) (See para T8.28 of explanatory notes to this Category) Fee: \$313.20 Benefit: 75% = \$234.90 85% = \$266.25	
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.) (See para T8.28 of explanatory notes to this Category) Fee: \$352.30 Benefit: 75% = \$264.25	
31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.) (See para T8.28 of explanatory notes to this Category) Fee: \$313.20 Benefit: 75% = \$234.90 85% = \$266.25	
31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.) (See para T8.28 of explanatory notes to this Category) Fee: \$587.20 Benefit: 75% = \$440.40	
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.) (See para T8.28 of explanatory notes to this Category) Fee: \$393.90 Benefit: 75% = \$295.45	
31518	BREAST (female), total mastectomy (Anaes.) (Assist.) Fee: \$664.90 Benefit: 75% = \$498.70	
31521	BREAST (male), total mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.) (See para T8.29 of explanatory notes to this Category) Fee: \$391.50 Benefit: 75% = \$293.65 85% = \$332.80	
31524	BREAST (female), subcutaneous mastectomy (Anaes.) (Assist.) (See para T8.29 of explanatory notes to this Category) Fee: \$939.45 Benefit: 75% = \$704.60	
31527	BREAST (male), subcutaneous mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.) (See para T8.29 of explanatory notes to this Category) Fee: \$469.80 Benefit: 75% = \$352.35 85% = \$404.60	
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: \$537.95 Benefit: 75% = \$403.50 85% = \$472.75	
31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) (See para T8.30 of explanatory notes to this Category) Fee: \$124.55 Benefit: 75% = \$93.45 85% = \$105.90	

OPERATIONS	COLORECTAL
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: \$171.05 Benefit: 75% = \$128.30 85% = \$145.40
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 T8.31 of explanatory notes to this Category)</i> Fee: \$360.15 Benefit: 75% = \$270.15
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 T8.32 of explanatory notes to this Category)</i> Fee: \$177.85 Benefit: 75% = \$133.40 85% = \$151.20
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 T8.31 of explanatory notes to this Category)</i> Fee: \$537.95 Benefit: 75% = \$403.50 85% = \$472.75
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: \$124.55 Benefit: 75% = \$93.45 85% = \$105.90
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, excluding aftercare (Anaes.) Fee: \$195.75 Benefit: 75% = \$146.85 85% = \$166.40
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.) Fee: \$391.50 Benefit: 75% = \$293.65
31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.) Fee: \$313.20 Benefit: 75% = \$234.90 85% = \$266.25
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) Fee: \$313.20 Benefit: 75% = \$234.90 85% = \$266.25
31563	INVERTED NIPPLE, surgical eversion of (Anaes.) Fee: \$234.60 Benefit: 75% = \$175.95 85% = \$199.45
31566	ACCESSORY NIPPLE, excision of (Anaes.) Fee: \$117.40 Benefit: 75% = \$88.05 85% = \$99.80
SUBGROUP 2 - COLORECTAL	
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) Fee: \$931.40 Benefit: 75% = \$698.55
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) Fee: \$974.30 Benefit: 75% = \$730.75
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: \$1,038.85 Benefit: 75% = \$779.15
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: \$1,173.60 Benefit: 75% = \$880.20

OPERATIONS	COLORECTAL
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.) Fee: \$1,038.85 Benefit: 75% = \$779.15
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) Fee: \$1,232.35 Benefit: 75% = \$924.30
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) Fee: \$1,361.30 Benefit: 75% = \$1,021.00
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) Fee: \$1,672.95 Benefit: 75% = \$1,254.75
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) Fee: \$1,418.55 Benefit: 75% = \$1,063.95
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) Fee: \$508.70 Benefit: 75% = \$381.55
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: \$1,232.35 Benefit: 75% = \$924.30
32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.) Fee: \$1,648.40 Benefit: 75% = \$1,236.30
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: \$1,775.15 Benefit: 75% = \$1,331.40
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.) Fee: \$1,902.05 Benefit: 75% = \$1,426.55
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.) Fee: \$380.40 Benefit: 75% = \$285.30
32030	RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes.) (Assist.) Fee: \$931.40 Benefit: 75% = \$698.55
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.) Fee: \$1,361.30 Benefit: 75% = \$1,021.00
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) Fee: \$1,726.55 Benefit: 75% = \$1,294.95
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) Fee: \$1,386.30 Benefit: 75% = \$1,039.75
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) Fee: \$1,167.80 Benefit: 75% = \$875.85
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) Fee: \$437.05 Benefit: 75% = \$327.80
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: \$675.40 Benefit: 75% = \$506.55

OPERATIONS		COLORECTAL
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) Fee: \$786.90 Benefit: 75% = \$590.20	
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: \$2,092.10 Benefit: 75% = \$1,569.10	
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: \$1,920.15 Benefit: 75% = \$1,440.15	
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) Fee: \$508.70 Benefit: 75% = \$381.55	
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: \$2,092.10 Benefit: 75% = \$1,569.10	
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: \$1,920.15 Benefit: 75% = \$1,440.15	
32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.) Fee: \$508.70 Benefit: 75% = \$381.55	
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) Fee: \$1,547.60 Benefit: 75% = \$1,160.70	
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy Fee: \$43.25 Benefit: 75% = \$32.45 85% = \$36.80	
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: \$67.75 Benefit: 75% = \$50.85 85% = \$57.60	
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: \$152.20 Benefit: 75% = \$114.15 85% = \$129.40	
32081	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes.) Fee: \$209.05 Benefit: 75% = \$156.80 85% = \$177.70	
32084	FLEXIBLE FIBROPTIC SIGMOIDOSCOPY or FIBROPTIC COLONOSCOPY up to the hepatic flexure, WITH or WITHOUT BIOPSY (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$100.55 Benefit: 75% = \$75.45 85% = \$85.50	
32087	FLEXIBLE FIBROPTIC SIGMOIDOSCOPY or FIBROPTIC 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: \$184.85 Benefit: 75% = \$138.65 85% = \$157.15	
32090	FIBROPTIC 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: \$301.90 Benefit: 75% = \$226.45 85% = \$256.65	
32093	FIBROPTIC 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: \$423.70 Benefit: 75% = \$317.80 85% = \$360.15	
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i> Fee: \$498.35 Benefit: 75% = \$373.80	

OPERATIONS		COLORECTAL
32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes.) (See para T8.20 of explanatory notes to this Category) Fee: \$115.45 Benefit: 75% = \$86.60 85% = \$98.15	
32096	RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.) Fee: \$232.05 Benefit: 75% = \$174.05 85% = \$197.25	
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.) Fee: \$300.95 Benefit: 75% = \$225.75	
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.) Fee: \$573.15 Benefit: 75% = \$429.90	
32103	RECTAL TUMOUR, of less than 4cm in diameter, per anal excision of, using stereoscopic rectoscopy (incorporating stereoscopic and optic systems), where removal is unable to be performed during colonoscopy or by local excision not being a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist.) (See para T8.20 and T8.33 of explanatory notes to this Category) Fee: \$697.45 Benefit: 75% = \$523.10	
32104	RECTAL TUMOUR, of 4cm or greater in diameter, per anal excision of, using stereoscopic rectoscopy (incorporating stereoscopic and optic systems), where removal is unable to be performed during colonoscopy or by local excision not being a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Anaes.) (Assist.) (See para T8.20 and T8.33 of explanatory notes to this Category) Fee: \$902.75 Benefit: 75% = \$677.10	
32105	ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.) Fee: \$437.05 Benefit: 75% = \$327.80 85% = \$371.85	
32106	ANTEROLATERAL INTRAPERITONEAL RECTAL TUMOUR, per anal excision of, using stereoscopic rectoscopy (incorporating stereoscopic and optic systems), where removal is unable to be performed during colonoscopy and where removal requires dissection within the peritoneal cavity not being a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.) (See para T8.20 and T8.33 of explanatory notes to this Category) Fee: \$1,232.35 Benefit: 75% = \$924.30 85% = \$1,167.15	
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) Fee: \$902.75 Benefit: 75% = \$677.10	
32111	RECTAL PROLAPSE Delorme procedure for (Anaes.) (Assist.) Fee: \$573.15 Benefit: 75% = \$429.90	
32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.) Fee: \$697.45 Benefit: 75% = \$523.10	
32114	RECTAL STRICTURE, per anal release of (Anaes.) Fee: \$157.60 Benefit: 75% = \$118.20 85% = \$134.00	
32115	RECTAL STRICTURE, dilatation of (Anaes.) Fee: \$114.55 Benefit: 75% = \$85.95	
32117	RECTAL PROLAPSE, abdominal rectopexy of (Anaes.) (Assist.) Fee: \$902.75 Benefit: 75% = \$677.10	
32120	RECTAL PROLAPSE, perineal repair of (Anaes.) (Assist.) Fee: \$232.05 Benefit: 75% = \$174.05	
32123	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.) Fee: \$300.95 Benefit: 75% = \$225.75 85% = \$255.85	
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.) Fee: \$437.05 Benefit: 75% = \$327.80	
32129	ANAL SPHINCTER, direct repair of (Anaes.) (Assist.) Fee: \$573.15 Benefit: 75% = \$429.90	

OPERATIONS		COLORECTAL
32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) Fee: \$481.85 Benefit: 75% = \$361.40	
32132	HAEMORRHOIDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.) Fee: \$40.75 Benefit: 75% = \$30.60 85% = \$34.65	
32135	HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.) Fee: \$60.95 Benefit: 75% = \$45.75 85% = \$51.85	
32138	HAEMORRHOIDECTOMY including excision of anal skin tags when performed (Anaes.) Fee: \$332.10 Benefit: 75% = \$249.10 85% = \$282.30	
32139	HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.) (Assist.) Fee: \$332.10 Benefit: 75% = \$249.10	
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (Anaes.) Fee: \$60.95 Benefit: 75% = \$45.75 85% = \$51.85	
32145	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.) Fee: \$122.00 Benefit: 75% = \$91.50 85% = \$103.70	
32147	PERIANAL THROMBOSIS, incision of (Anaes.) Fee: \$40.75 Benefit: 75% = \$30.60 85% = \$34.65	
32150	OPERATION FOR FISSURE IN ANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.) Fee: \$232.05 Benefit: 75% = \$174.05 85% = \$197.25	
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: \$63.30 Benefit: 75% = \$47.50	
32156	FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes.) Fee: \$118.95 Benefit: 75% = \$89.25 85% = \$101.15	
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: \$300.95 Benefit: 75% = \$225.75	
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: \$437.05 Benefit: 75% = \$327.80	
32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.) Fee: \$573.15 Benefit: 75% = \$429.90 85% = \$507.95	
32166	ANAL FISTULA - readjustment of Seton (Anaes.) Fee: \$186.20 Benefit: 75% = \$139.65 85% = \$158.30	
32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes.) Fee: \$118.95 Benefit: 75% = \$89.25	
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: \$80.20 Benefit: 75% = \$60.15	
32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) Fee: \$80.20 Benefit: 75% = \$60.15 85% = \$68.20	
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.) Fee: \$146.85 Benefit: 75% = \$110.15	

OPERATIONS		COLORECTAL
32177	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, 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: \$157.40 Benefit: 75% = \$118.05	
32180	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, 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: \$232.05 Benefit: 75% = \$174.05	
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) Fee: \$507.25 Benefit: 75% = \$380.45	
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) Fee: \$507.25 Benefit: 75% = \$380.45	
32200	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.) Fee: \$267.00 Benefit: 75% = \$200.25 85% = \$226.95	
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.) Fee: \$573.45 Benefit: 75% = \$430.10	
32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.) Fee: \$518.10 Benefit: 75% = \$388.60	
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.) Fee: \$832.55 Benefit: 75% = \$624.45	
32210	GRACILIS NEOSPINCTER PACEMAKER, replacement of (Anaes.) Fee: \$230.70 Benefit: 75% = \$173.05 85% = \$196.10	
32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.) Fee: \$123.05 Benefit: 75% = \$92.30 85% = \$104.60	
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 T8.34 of explanatory notes to this Category)</i> Fee: \$596.90 Benefit: 75% = \$447.70	
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 T8.34 of explanatory notes to this Category)</i> Fee: \$301.55 Benefit: 75% = \$226.20	
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 T8.34 of explanatory notes to this Category)</i> Fee: \$113.25 Benefit: 75% = \$84.95 85% = \$96.30	
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 T8.34 of explanatory notes to this Category)</i> Fee: \$536.05 Benefit: 75% = \$402.05	
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 T8.34 of explanatory notes to this Category)</i> Fee: \$141.20 Benefit: 75% = \$105.90	

OPERATIONS		VASCULAR
32218	SACRAL NERVE LEAD(S), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.) (See para T8.34 of explanatory notes to this Category) Fee: \$141.20 Benefit: 75% = \$105.90	
SUBGROUP 3 - VASCULAR		
VARICOSE VEINS		
32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding after-care) - to a maximum of 6 treatments in a 12 month period (Anaes.) (See para T8.35 of explanatory notes to this Category) Fee: \$99.15 Benefit: 75% = \$74.40 85% = \$84.30	
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 - <i>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 T8.35 of explanatory notes to this Category) Fee: \$99.15 Benefit: 75% = \$74.40 85% = \$84.30	
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: \$241.70 Benefit: 75% = \$181.30 85% = \$205.45	
32507	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (Assist.) Fee: \$481.85 Benefit: 75% = \$361.40 85% = \$416.65	
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: \$481.85 Benefit: 75% = \$361.40	
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: \$716.40 Benefit: 75% = \$537.30	
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: \$836.95 Benefit: 75% = \$627.75	
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: \$1,077.75 Benefit: 75% = \$808.35	
BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE		
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) Fee: \$1,297.05 Benefit: 75% = \$972.80	
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.) Fee: \$1,073.05 Benefit: 75% = \$804.80	
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) Fee: \$1,283.60 Benefit: 75% = \$962.70	
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) Fee: \$1,426.25 Benefit: 75% = \$1,069.70	

OPERATIONS		VASCULAR
32711	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.) (Assist.) Fee: \$1,568.85 Benefit: 75% = \$1,176.65	
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) Fee: \$1,134.10 Benefit: 75% = \$850.60	
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) Fee: \$1,134.10 Benefit: 75% = \$850.60	
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) Fee: \$1,073.05 Benefit: 75% = \$804.80	
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) Fee: \$1,704.45 Benefit: 75% = \$1,278.35	
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) Fee: \$1,935.40 Benefit: 75% = \$1,451.55	
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) Fee: \$1,466.85 Benefit: 75% = \$1,100.15	
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) Fee: \$1,704.45 Benefit: 75% = \$1,278.35	
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) Fee: \$373.45 Benefit: 75% = \$280.10	
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: \$1,168.05 Benefit: 75% = \$876.05	
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: \$1,337.95 Benefit: 75% = \$1,003.50	
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: \$1,527.95 Benefit: 75% = \$1,146.00	
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: \$1,657.00 Benefit: 75% = \$1,242.75	
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) Fee: \$1,073.05 Benefit: 75% = \$804.80	
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: \$1,337.95 Benefit: 75% = \$1,003.50	
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: \$373.45 Benefit: 75% = \$280.10	
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: \$366.70 Benefit: 75% = \$275.05	
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: \$1,073.05 Benefit: 75% = \$804.80	

OPERATIONS		VASCULAR
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.) Fee: \$713.10 Benefit: 75% = \$534.85	
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: \$247.15 Benefit: 75% = \$185.40	
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: \$1,314.25 Benefit: 75% = \$985.70	
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) Fee: \$1,053.95 Benefit: 75% = \$790.50	
33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$760.40 Benefit: 75% = \$570.30 85% = \$695.20	
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$967.30 Benefit: 75% = \$725.50	
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,180.70 Benefit: 75% = \$885.55	
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.) Fee: \$1,297.05 Benefit: 75% = \$972.80 85% = \$1,231.85	
33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$1,819.95 Benefit: 75% = \$1,365.00	
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) Fee: \$2,200.35 Benefit: 75% = \$1,650.30 85% = \$2,135.15	
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) Fee: \$1,908.30 Benefit: 75% = \$1,431.25	
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) Fee: \$1,283.60 Benefit: 75% = \$962.70	
‡ 33116	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) Fee: \$1,263.40 Benefit: 75% = \$947.55 85% = \$1,198.20	
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.) Fee: \$1,426.25 Benefit: 75% = \$1,069.70	
‡ 33119	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) Fee: \$1,403.85 Benefit: 75% = \$1,052.90 85% = \$1,338.65	
33121	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) Fee: \$1,568.85 Benefit: 75% = \$1,176.65	
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.) Fee: \$1,093.40 Benefit: 75% = \$820.05	
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.) Fee: \$1,432.95 Benefit: 75% = \$1,074.75 85% = \$1,367.75	

OPERATIONS		VASCULAR
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) Fee: \$1,249.55 Benefit: 75% = \$937.20	
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) Fee: \$937.10 Benefit: 75% = \$702.85	
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) Fee: \$2,363.15 Benefit: 75% = \$1,772.40	
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) Fee: \$1,432.95 Benefit: 75% = \$1,074.75	
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.) Fee: \$1,337.95 Benefit: 75% = \$1,003.50 85% = \$1,272.75	
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$2,302.15 Benefit: 75% = \$1,726.65	
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$2,859.00 Benefit: 75% = \$2,144.25	
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$2,716.35 Benefit: 75% = \$2,037.30	
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) Fee: \$2,010.15 Benefit: 75% = \$1,507.65	
33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) Fee: \$2,241.00 Benefit: 75% = \$1,680.75	
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) Fee: \$2,241.00 Benefit: 75% = \$1,680.75	
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$1,901.65 Benefit: 75% = \$1,426.25	
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) Fee: \$1,901.65 Benefit: 75% = \$1,426.25 85% = \$1,836.45	
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) Fee: \$1,480.45 Benefit: 75% = \$1,110.35	
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) Fee: \$1,154.45 Benefit: 75% = \$865.85	
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,063.95 Benefit: 75% = \$798.00	
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,352.95 Benefit: 75% = \$1,014.75	
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,654.20 Benefit: 75% = \$1,240.65	
ENDARTERECTOMY AND ARTERIAL PATCH		
33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.) Fee: \$1,025.35 Benefit: 75% = \$769.05	
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) Fee: \$1,147.75 Benefit: 75% = \$860.85	

OPERATIONS	VASCULAR
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) Fee: \$1,283.60 Benefit: 75% = \$962.70
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: \$1,426.25 Benefit: 75% = \$1,069.70
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: \$1,568.85 Benefit: 75% = \$1,176.65
33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.) Fee: \$1,147.75 Benefit: 75% = \$860.85 85% = \$1,082.55
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) Fee: \$1,242.70 Benefit: 75% = \$932.05
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) Fee: \$1,466.85 Benefit: 75% = \$1,100.15
33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) Fee: \$1,704.45 Benefit: 75% = \$1,278.35
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) Fee: \$1,466.85 Benefit: 75% = \$1,100.15
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) Fee: \$1,704.45 Benefit: 75% = \$1,278.35
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: \$1,215.65 Benefit: 75% = \$911.75
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) Fee: \$876.05 Benefit: 75% = \$657.05
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.) Fee: \$1,249.55 Benefit: 75% = \$937.20
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: \$247.15 Benefit: 75% = \$185.40
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: \$502.65 Benefit: 75% = \$377.00
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: \$247.15 Benefit: 75% = \$185.40
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.) Fee: \$245.95 Benefit: 75% = \$184.50
EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA	
33800	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.) Fee: \$1,066.20 Benefit: 75% = \$799.65 85% = \$1,001.00
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) Fee: \$1,018.70 Benefit: 75% = \$764.05

OPERATIONS		VASCULAR
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: \$733.45 Benefit: 75% = \$550.10 85% = \$668.25	
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.) Fee: \$535.00 Benefit: 75% = \$401.25 85% = \$469.80	
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) Fee: \$1,592.80 Benefit: 75% = \$1,194.60	
33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.) Fee: \$842.10 Benefit: 75% = \$631.60 85% = \$776.90	
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) Fee: \$774.20 Benefit: 75% = \$580.65	
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) Fee: \$903.25 Benefit: 75% = \$677.45	
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: \$1,032.20 Benefit: 75% = \$774.15	
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) Fee: \$984.65 Benefit: 75% = \$738.50	
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) Fee: \$1,154.45 Benefit: 75% = \$865.85	
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: \$1,324.20 Benefit: 75% = \$993.15	
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) Fee: \$1,202.15 Benefit: 75% = \$901.65	
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.) Fee: \$1,432.95 Benefit: 75% = \$1,074.75	
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) Fee: \$1,677.35 Benefit: 75% = \$1,258.05	
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) Fee: \$828.50 Benefit: 75% = \$621.40	
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) Fee: \$577.25 Benefit: 75% = \$432.95	
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) Fee: \$577.25 Benefit: 75% = \$432.95	
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: \$638.45 Benefit: 75% = \$478.85	

OPERATIONS		VASCULAR
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: \$373.45 Benefit: 75% = \$280.10	
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: \$263.45 Benefit: 75% = \$197.60 85% = \$223.95	
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) Fee: \$305.55 Benefit: 75% = \$229.20 85% = \$259.75	
34112	ARTERIO-VEIN FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) Fee: \$774.20 Benefit: 75% = \$580.65	
34115	ARTERIO-VEIN FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) Fee: \$876.05 Benefit: 75% = \$657.05	
34118	ARTERIO-VEIN FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) Fee: \$1,249.55 Benefit: 75% = \$937.20 85% = \$1,184.35	
34121	ARTERIO-VEIN FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) Fee: \$998.25 Benefit: 75% = \$748.70	
34124	ARTERIO-VEIN FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) Fee: \$1,093.40 Benefit: 75% = \$820.05	
34127	ARTERIO-VEIN FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) Fee: \$1,432.95 Benefit: 75% = \$1,074.75	
34130	SURGICALLY CREATED ARTERIO-VEIN FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) Fee: \$448.20 Benefit: 75% = \$336.15 85% = \$383.00	
34133	SCALENOTOMY (Anaes.) (Assist.) Fee: \$502.65 Benefit: 75% = \$377.00	
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) Fee: \$808.05 Benefit: 75% = \$606.05	
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: \$808.05 Benefit: 75% = \$606.05	
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) Fee: \$998.25 Benefit: 75% = \$748.70	
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) Fee: \$726.65 Benefit: 75% = \$545.00	
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: \$1,297.05 Benefit: 75% = \$972.80	
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: \$1,772.45 Benefit: 75% = \$1,329.35	
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) Fee: \$2,112.05 Benefit: 75% = \$1,584.05 85% = \$2,046.85	
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) Fee: \$1,073.05 Benefit: 75% = \$804.80	

OPERATIONS		VASCULAR
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) Fee: \$2,010.15 Benefit: 75% = \$1,507.65	
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) Fee: \$2,580.60 Benefit: 75% = \$1,935.45	
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) Fee: \$2,580.60 Benefit: 75% = \$1,935.45	
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) Fee: \$1,432.95 Benefit: 75% = \$1,074.75	
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) Fee: \$1,168.05 Benefit: 75% = \$876.05	
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) Fee: \$1,073.05 Benefit: 75% = \$804.80	
OPERATIONS FOR VASCULAR ACCESS		
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.) Fee: \$278.50 Benefit: 75% = \$208.90 85% = \$236.75	
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) Fee: \$373.45 Benefit: 75% = \$280.10	
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) Fee: \$190.10 Benefit: 75% = \$142.60	
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.) Fee: \$882.80 Benefit: 75% = \$662.10	
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) Fee: \$971.15 Benefit: 75% = \$728.40	
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) Fee: \$692.65 Benefit: 75% = \$519.50	
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) Fee: \$1,161.20 Benefit: 75% = \$870.90	
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) Fee: \$713.35 Benefit: 75% = \$535.05	
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) Fee: \$373.45 Benefit: 75% = \$280.10	
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: \$498.15 Benefit: 75% = \$373.65 85% = \$432.95	
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: \$245.95 Benefit: 75% = \$184.50 85% = \$209.10	
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: \$184.45 Benefit: 75% = \$138.35 85% = \$156.80	

OPERATIONS		VASCULAR
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: \$1,120.45 Benefit: 75% = \$840.35 85% = \$1,055.25	
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: \$245.95 Benefit: 75% = \$184.50 85% = \$209.10	
34539	TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital (Anaes.) Fee: \$184.45 Benefit: 75% = \$138.35 85% = \$156.80	
COMPLEX VENOUS OPERATIONS		
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) Fee: \$733.45 Benefit: 75% = \$550.10 85% = \$668.25	
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) Fee: \$1,616.35 Benefit: 75% = \$1,212.30	
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) Fee: \$876.05 Benefit: 75% = \$657.05	
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) Fee: \$876.05 Benefit: 75% = \$657.05	
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: \$1,059.40 Benefit: 75% = \$794.55	
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: \$876.05 Benefit: 75% = \$657.05	
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) Fee: \$964.30 Benefit: 75% = \$723.25	
34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) Fee: \$1,310.75 Benefit: 75% = \$983.10 85% = \$1,245.55	
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) Fee: \$448.20 Benefit: 75% = \$336.15	
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) Fee: \$543.30 Benefit: 75% = \$407.50	
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) Fee: \$638.45 Benefit: 75% = \$478.85 85% = \$573.25	
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) Fee: \$828.50 Benefit: 75% = \$621.40	
SYMPATHECTOMY		
35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) Fee: \$638.45 Benefit: 75% = \$478.85 85% = \$573.25	
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) Fee: \$828.50 Benefit: 75% = \$621.40	
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) Fee: \$1,039.05 Benefit: 75% = \$779.30	

OPERATIONS		VASCULAR
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) Fee: \$808.05 Benefit: 75% = \$606.05	
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) Fee: \$638.45 Benefit: 75% = \$478.85	
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: \$332.85 Benefit: 75% = \$249.65	
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) Fee: \$211.85 Benefit: 75% = \$158.90 85% = \$180.10	
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: \$154.90 Benefit: 75% = \$116.20	
35202	MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.) Fee: \$737.95 Benefit: 75% = \$553.50	
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: \$465.45 Benefit: 75% = \$349.10 85% = \$400.25	
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: \$596.75 Benefit: 75% = \$447.60 85% = \$531.55	
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: \$550.80 Benefit: 75% = \$413.10 85% = \$485.60	
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: \$1,012.55 Benefit: 75% = \$759.45	
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: \$688.50 Benefit: 75% = \$516.40 85% = \$623.30	
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: \$780.30 Benefit: 75% = \$585.25	
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: \$780.30 Benefit: 75% = \$585.25	

OPERATIONS		VASCULAR
35317	<p>PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) (See para T8.41 of explanatory notes to this Category)</p> <p>Fee: \$321.30 Benefit: 75% = \$241.00 85% = \$273.15</p>	
35319	<p>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.)</p> <p>Fee: \$576.00 Benefit: 75% = \$432.00 85% = \$510.80</p>	
35320	<p>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.)</p> <p>Fee: \$773.70 Benefit: 75% = \$580.30 85% = \$708.50</p>	
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: \$734.45 Benefit: 75% = \$550.85 85% = \$669.25</p>	
35324	<p>ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p>Fee: \$275.35 Benefit: 75% = \$206.55</p>	
35327	<p>ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)</p> <p>Fee: \$369.10 Benefit: 75% = \$276.85</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: \$465.45 Benefit: 75% = \$349.10 85% = \$400.25</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: \$535.00 Benefit: 75% = \$401.25</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 <i>(foreign body does not include an instrument inserted for the purpose of a service being rendered)</i> (Anaes.) (Assist.)</p> <p>Fee: \$747.90 Benefit: 75% = \$560.95</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 <i>(foreign body does not include an instrument inserted for the purpose of a service being rendered)</i> (Anaes.) (Assist.)</p> <p>Fee: \$641.45 Benefit: 75% = \$481.10</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 <i>(foreign body does not include an instrument inserted for the purpose of a service being rendered)</i> (Anaes.) (Assist.)</p> <p>Fee: \$535.00 Benefit: 75% = \$401.25</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 <i>(foreign body does not include an instrument inserted for the purpose of a service being rendered)</i> (Anaes.) (Assist.)</p> <p>Fee: \$428.65 Benefit: 75% = \$321.50</p>	

OPERATIONS		GYNAECOLOGICAL	
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.) <i>(See para T8.43 of explanatory notes to this Category)</i></p>	Fee: \$596.75	Benefit: 75% = \$447.60 85% = \$531.55
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.) <i>(See para T8.43 of explanatory notes to this Category)</i></p>	Fee: \$596.75	Benefit: 75% = \$447.60 85% = \$531.55
35404	<p>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></p>	Fee: \$313.05	Benefit: 75% = \$234.80
35406	<p>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></p>	Fee: \$734.45	Benefit: 75% = \$550.85
35408	<p>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></p>	Fee: \$550.95	Benefit: 75% = \$413.25
35410	<p>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></p>	Fee: \$734.45	Benefit: 75% = \$550.85 85% = \$669.25
35412	<p>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></p>	Fee: \$2,580.60	Benefit: 75% = \$1,935.45 85% = \$2,515.40
SUBGROUP 4 - GYNAECOLOGICAL			
35500	<p>GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)</p>	Fee: \$73.40	Benefit: 75% = \$55.05 85% = \$62.40
35502	<p>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.)</p>	Fee: \$72.40	Benefit: 75% = \$54.30 85% = \$61.55
35503	<p>INTRAUTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this Group applies (Anaes.)</p>	Fee: \$48.35	Benefit: 75% = \$36.30 85% = \$41.10

OPERATIONS		GYNAECOLOGICAL	
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: \$609.10 Benefit: 75% = \$456.85		
35602	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; abdominal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) Fee: \$609.10 Benefit: 75% = \$456.85		
35605	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; vaginal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.) Fee: \$330.45 Benefit: 75% = \$247.85 85% = \$280.90		
35608	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.) Fee: \$57.75 Benefit: 75% = \$43.35 85% = \$49.10		
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: \$57.75 Benefit: 75% = \$43.35 85% = \$49.10		
35612	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.) Fee: \$456.95 Benefit: 75% = \$342.75 85% = \$391.75		
35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.) Fee: \$365.55 Benefit: 75% = \$274.20		
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: \$57.65 Benefit: 75% = \$43.25 85% = \$49.05		
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies Fee: \$48.50 Benefit: 75% = \$36.40 85% = \$41.25		
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: \$406.00 Benefit: 75% = \$304.50		
35617 G 35618 S	CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35577 or 35578 applies (Anaes.) Fee: \$156.85 Benefit: 75% = \$117.65 85% = \$133.35 Fee: \$196.85 Benefit: 75% = \$147.65 85% = \$167.35		
35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.) Fee: \$48.15 Benefit: 75% = \$36.15 85% = \$40.95		
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: \$544.05 Benefit: 75% = \$408.05		
35623	HYSTEROSCOPIC RESECTION of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.) Fee: \$739.85 Benefit: 75% = \$554.90		
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: \$74.80 Benefit: 75% = \$56.10 85% = \$63.60		
35627	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35630 applies (Anaes.) Fee: \$96.75 Benefit: 75% = \$72.60		

OPERATIONS		GYNAECOLOGICAL	
35630	HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35627 applies (Anaes.) Fee: \$165.30 Benefit: 75% = \$124.00 85% = \$140.55		
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: \$196.85 Benefit: 75% = \$147.65 85% = \$167.35		
35634	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.) Fee: \$619.25 Benefit: 75% = \$464.45 85% = \$554.05		
35635	HYSTEROSCOPY involving resection of the uterine septum (Anaes.) Fee: \$270.45 Benefit: 75% = \$202.85		
35636	HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.) Fee: \$391.05 Benefit: 75% = \$293.30		
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: \$367.25 Benefit: 75% = \$275.45		
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: \$642.55 Benefit: 75% = \$481.95		
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, 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: \$121.85 Benefit: 75% = \$91.40 Fee: \$165.30 Benefit: 75% = \$124.00		
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: \$1,122.25 Benefit: 75% = \$841.70		
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: \$196.85 Benefit: 75% = \$147.65 85% = \$167.35		
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: \$183.90 Benefit: 75% = \$137.95 85% = \$156.35		
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.) <i>(See para T8.50 of explanatory notes to this Category)</i> Fee: \$287.85 Benefit: 75% = \$215.90 85% = \$244.70		
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital (Anaes.) <i>(See para T8.50 of explanatory notes to this Category)</i> Fee: \$183.90 Benefit: 75% = \$137.95 85% = \$156.35		

OPERATIONS		GYNAECOLOGICAL	
35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.) (See para T8.50 of explanatory notes to this Category)	Fee: \$183.90	Benefit: 75% = \$137.95 85% = \$156.35
35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.) (See para T8.50 of explanatory notes to this Category)	Fee: \$287.85	Benefit: 75% = \$215.90 85% = \$244.70
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.)	Fee: \$484.05	Benefit: 75% = \$363.05
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.)	Fee: \$609.25	Benefit: 75% = \$456.95
35657	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Anaes.) (Assist.) (See para T8.51 of explanatory notes to this Category)	Fee: \$609.25	Benefit: 75% = \$456.95
35658	UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.) (Assist.) (See para T8.52 of explanatory notes to this Category)	Fee: \$375.70	Benefit: 75% = \$281.80
35661	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (Anaes.) (Assist.)	Fee: \$786.90	Benefit: 75% = \$590.20
35664	RADICAL HYSTERECTOMY with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.)	Fee: \$1,311.45	Benefit: 75% = \$983.60
35667	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.)	Fee: \$1,114.60	Benefit: 75% = \$835.95
35670	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Anaes.) (Assist.)	Fee: \$917.80	Benefit: 75% = \$688.35
35673	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.)	Fee: \$684.30	Benefit: 75% = \$513.25
35674	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy	Fee: \$187.70	Benefit: 75% = \$140.80 85% = \$159.55
35676 G	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.)	Fee: \$383.75	Benefit: 75% = \$287.85
35677 S		Fee: \$484.05	Benefit: 75% = \$363.05
35678	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.)	Fee: \$583.60	Benefit: 75% = \$437.70
35680	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.)	Fee: \$525.65	Benefit: 75% = \$394.25 85% = \$460.45

OPERATIONS		GYNAECOLOGICAL	
35683 G 35684 S	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.) Fee: \$317.25 Benefit: 75% = \$237.95		
		Fee: \$425.50	Benefit: 75% = \$319.15
35687 G 35688 S	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method. NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Anaes.) (Assist.) (See para T8.51 of explanatory notes to this Category)	Fee: \$293.70	Benefit: 75% = \$220.30
		Fee: \$358.75	Benefit: 75% = \$269.10
35691	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Anaes.) (Assist.) (See para T8.51 of explanatory notes to this Category)	Fee: \$143.35	Benefit: 75% = \$107.55
35694	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)	Fee: \$575.90	Benefit: 75% = \$431.95
35697	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)	Fee: \$854.50	Benefit: 75% = \$640.90
35700	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)	Fee: \$659.35	Benefit: 75% = \$494.55
35703	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.)	Fee: \$60.95	Benefit: 75% = \$45.75 85% = \$51.85
35706	RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes.)	Fee: \$60.95	Benefit: 75% = \$45.75 85% = \$51.85
35709	FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes.)	Fee: \$39.30	Benefit: 75% = \$29.50 85% = \$33.45
35710	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.)	Fee: \$418.40	Benefit: 75% = \$313.80
35712 G 35713 S	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.)	Fee: \$327.10	Benefit: 75% = \$245.35
		Fee: \$409.00	Benefit: 75% = \$306.75
35716 G 35717 S	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.)	Fee: \$392.25	Benefit: 75% = \$294.20
		Fee: \$492.40	Benefit: 75% = \$369.30
35720	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.) (See para T8.61 of explanatory notes to this Category)	Fee: \$609.10	Benefit: 75% = \$456.85

OPERATIONS	UROLOGICAL
35723	RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) Fee: \$436.30 Benefit: 75% = \$327.25
35726	INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) Fee: \$436.30 Benefit: 75% = \$327.25
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.) Fee: \$196.70 Benefit: 75% = \$147.55
35750	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.) Fee: \$708.55 Benefit: 75% = \$531.45
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: \$783.50 Benefit: 75% = \$587.65
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: \$986.05 Benefit: 75% = \$739.55
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.) Fee: \$708.55 Benefit: 75% = \$531.45
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: \$508.70 Benefit: 75% = \$381.55
SUBGROUP 5 - UROLOGICAL	
GENERAL	
36500	ADRENAL GLAND, excision of partial or total (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) Fee: \$617.60 Benefit: 75% = \$463.20
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) Fee: \$1,256.35 Benefit: 75% = \$942.30
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) Fee: \$707.10 Benefit: 75% = \$530.35
36516	NEPHRECTOMY, complete (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
36519	NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.) Fee: \$1,166.00 Benefit: 75% = \$874.50
36522	NEPHRECTOMY, partial (Anaes.) (Assist.) Fee: \$1,000.60 Benefit: 75% = \$750.45
36525	NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.) Fee: \$1,421.85 Benefit: 75% = \$1,066.40

OPERATIONS	UROLOGICAL
36526	<p>NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10cms in diameter, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) (See para T8.54 of explanatory notes to this Category) Fee: \$1,166.00 Benefit: 75% = \$874.50 85% = \$1,100.80</p>
36527	<p>NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) (See para T8.54 of explanatory notes to this Category) Fee: \$1,439.00 Benefit: 75% = \$1,079.25 85% = \$1,373.80</p>
36528	<p>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: \$1,166.00 Benefit: 75% = \$874.50</p>
36529	<p>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: \$1,439.00 Benefit: 75% = \$1,079.25</p>
36531	<p>NEPHROURETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) Fee: \$1,045.60 Benefit: 75% = \$784.20</p>
36532	<p>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: \$1,500.80 Benefit: 75% = \$1,125.60</p>
36533	<p>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: \$1,773.80 Benefit: 75% = \$1,330.35</p>
36537	<p>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: \$624.40 Benefit: 75% = \$468.30</p>
36540	<p>NEPHROLITHOTOMY OR PYEOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (Anaes.) (Assist.) Fee: \$1,000.60 Benefit: 75% = \$750.45 85% = \$935.40</p>
36543	<p>NEPHROLITHOTOMY OR PYEOLITHOTOMY, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.) Fee: \$1,166.00 Benefit: 75% = \$874.50 85% = \$1,100.80</p>
36546	<p>EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) Fee: \$624.40 Benefit: 75% = \$468.30 85% = \$559.20</p>
36549	<p>URETEROLITHOTOMY (Anaes.) (Assist.) Fee: \$752.35 Benefit: 75% = \$564.30</p>
36552	<p>NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) Fee: \$669.65 Benefit: 75% = \$502.25</p>
36558	<p>RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) Fee: \$586.85 Benefit: 75% = \$440.15 85% = \$521.65</p>
36561	<p>RENAL BIOPSY (closed) (Anaes.) Fee: \$155.80 Benefit: 75% = \$116.85 85% = \$132.45</p>
36564	<p>PYELOPLASTY, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30</p>

OPERATIONS	UROLOGICAL
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: \$917.80 Benefit: 75% = \$688.35
36570	PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (Anaes.) (Assist.) Fee: \$1,166.00 Benefit: 75% = \$874.50
36573	DIVIDED URETER, repair of (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
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: \$1,045.60 Benefit: 75% = \$784.20
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: \$669.65 Benefit: 75% = \$502.25
36585	URETER, transplantation of, into skin (Anaes.) (Assist.) Fee: \$669.65 Benefit: 75% = \$502.25
36588	URETER, reimplantation into bladder (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) Fee: \$1,000.60 Benefit: 75% = \$750.45
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) Fee: \$1,000.60 Benefit: 75% = \$750.45 85% = \$935.40
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) Fee: \$1,166.00 Benefit: 75% = \$874.50
36604	URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.) Fee: \$241.70 Benefit: 75% = \$181.30 85% = \$205.45
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: \$623.70 Benefit: 75% = \$467.80
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) Fee: \$2,091.35 Benefit: 75% = \$1,568.55
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: \$623.70 Benefit: 75% = \$467.80
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: \$241.70 Benefit: 75% = \$181.30
36609	INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.) Fee: \$669.65 Benefit: 75% = \$502.25

OPERATIONS	UROLOGICAL
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) Fee: \$586.85 Benefit: 75% = \$440.15
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: \$669.65 Benefit: 75% = \$502.25
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) Fee: \$586.85 Benefit: 75% = \$440.15
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) Fee: \$419.50 Benefit: 75% = \$314.65
36624	NEPHROSTOMY, percutaneous, using interventional imaging techniques (Anaes.) (Assist.) Fee: \$504.00 Benefit: 75% = \$378.00 85% = \$438.80
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: \$624.40 Benefit: 75% = \$468.30
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: \$308.45 Benefit: 75% = \$231.35
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: \$669.65 Benefit: 75% = \$502.25 85% = \$604.45
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: \$361.15 Benefit: 75% = \$270.90
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: \$752.35 Benefit: 75% = \$564.30
36642	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) Fee: \$376.10 Benefit: 75% = \$282.10
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: \$962.95 Benefit: 75% = \$722.25
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: \$857.60 Benefit: 75% = \$643.20
36649	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (Anaes.) (Assist.) Fee: \$241.70 Benefit: 75% = \$181.30 85% = \$205.45
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: \$135.15 Benefit: 75% = \$101.40
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: \$586.85 Benefit: 75% = \$440.15
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: \$752.35 Benefit: 75% = \$564.30

OPERATIONS		UROLOGICAL
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: \$962.95 Benefit: 75% = \$722.25	
+ 36658	SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal of pulse generator and leads <i>(See para T8.55 of explanatory notes to this Category)</i> Fee: \$475.35 Benefit: 75% = \$356.55 85% = \$410.15	
+ 36660	SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal and replacement of pulse generator <i>(See para T8.55 of explanatory notes to this Category)</i> Fee: \$230.70 Benefit: 75% = \$173.05 85% = \$196.10	
+ 36662	SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal and replacement of leads <i>(See para T8.55 of explanatory notes to this Category)</i> Fee: \$551.10 Benefit: 75% = \$413.35 85% = \$485.90	
OPERATIONS ON BLADDER (CLOSED)		
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) Fee: \$24.95 Benefit: 75% = \$18.75 85% = \$21.25	
36803	URETEROSCOPY, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Anaes.) (Assist.) <i>(See para T8.56 of explanatory notes to this Category)</i> Fee: \$421.15 Benefit: 75% = \$315.90 85% = \$358.00	
36806	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) Fee: \$586.85 Benefit: 75% = \$440.15	
36809	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, PLUS destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) Fee: \$752.35 Benefit: 75% = \$564.30	
36811	CYSTOSCOPY with insertion of urethral prosthesis (Anaes.) Fee: \$292.10 Benefit: 75% = \$219.10 85% = \$248.30	
36812	CYSTOSCOPY with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.) Fee: \$150.55 Benefit: 75% = \$112.95 85% = \$128.00	
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or urethral warts, not being a service associated with a service to which item 30189 applies (Anaes.) <i>(See para T8.13 of explanatory notes to this Category)</i> Fee: \$214.80 Benefit: 75% = \$161.10 85% = \$182.60	
36818	CYSTOSCOPY with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) Fee: \$249.80 Benefit: 75% = \$187.35 85% = \$212.35	
36821	CYSTOSCOPY with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) Fee: \$291.90 Benefit: 75% = \$218.95 85% = \$248.15	
36824	CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.) Fee: \$192.45 Benefit: 75% = \$144.35 85% = \$163.60	

OPERATIONS		UROLOGICAL
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) Fee: \$669.65 Benefit: 75% = \$502.25	
37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) Fee: \$376.10 Benefit: 75% = \$282.10	
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) Fee: \$376.10 Benefit: 75% = \$282.10	
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30	
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) Fee: \$624.75 Benefit: 75% = \$468.60	
37041	BLADDER ASPIRATION by needle Fee: \$42.10 Benefit: 75% = \$31.60 85% = \$35.80	
37042	BLADDER STRESS INCONTINENCE, sling procedure for, using autologous fascial sling, including harvesting of sling, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) Fee: \$822.95 Benefit: 75% = \$617.25	
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: \$609.10 Benefit: 75% = \$456.85	
37044	BLADDER STRESS INCONTINENCE, suprapubic procedure for, eg Burch colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) Fee: \$624.75 Benefit: 75% = \$468.60	
37045	MITROFANOFF CONTINENT VALVE, formation of (Anaes.) (Assist.) Fee: \$1,290.25 Benefit: 75% = \$967.70	
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) Fee: \$1,504.60 Benefit: 75% = \$1,128.45	
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) Fee: \$669.65 Benefit: 75% = \$502.25	
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) Fee: \$773.70 Benefit: 75% = \$580.30	
OPERATIONS ON PROSTATE		
37200	PROSTATECTOMY, open (Anaes.) (Assist.) Fee: \$917.80 Benefit: 75% = \$688.35	
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.) Fee: \$748.55 Benefit: 75% = \$561.45	
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.) Fee: \$375.70 Benefit: 75% = \$281.80 85% = \$319.35	
37203	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) Fee: \$941.10 Benefit: 75% = \$705.85	

OPERATIONS	UROLOGICAL
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: \$504.00 Benefit: 75% = \$378.00 85% = \$438.80
OPERATIONS ON URETHRA, PENIS OR SCROTUM	
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) Fee: \$42.10 Benefit: 75% = \$31.60 85% = \$35.80
37303	URETHRAL STRICTURE, dilatation of (Anaes.) Fee: \$66.90 Benefit: 75% = \$50.20 85% = \$56.90
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) Fee: \$586.85 Benefit: 75% = \$440.15
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
37315	URETHROSCOPY, as an independent procedure (Anaes.) Fee: \$124.90 Benefit: 75% = \$93.70 85% = \$106.20
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: \$249.80 Benefit: 75% = \$187.35 85% = \$212.35
37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.) Fee: \$84.25 Benefit: 75% = \$63.20 85% = \$71.65
37324	URETHROTOMY OR URETHROSTOMY, internal or external (Anaes.) Fee: \$207.60 Benefit: 75% = \$155.70
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) Fee: \$291.90 Benefit: 75% = \$218.95
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) Fee: \$586.85 Benefit: 75% = \$440.15
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) Fee: \$504.00 Benefit: 75% = \$378.00
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) Fee: \$669.65 Benefit: 75% = \$502.25
37339	PERIURETHRAL OR TRANSURETHRAL INJECTION of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy (Anaes.) Fee: \$216.60 Benefit: 75% = \$162.45 85% = \$184.15
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: \$383.75 Benefit: 75% = \$287.85
37341	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined suprapubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Anaes.) (Assist.) Fee: \$822.95 Benefit: 75% = \$617.25
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.) Fee: \$752.35 Benefit: 75% = \$564.30
37343	URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.) Fee: \$1,256.35 Benefit: 75% = \$942.30

OPERATIONS	UROLOGICAL
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) Fee: \$624.40 Benefit: 75% = \$468.30
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) Fee: \$624.40 Benefit: 75% = \$468.30
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$249.80 Benefit: 75% = \$187.35
37354	HYPOSPADIAS, meatotomy and hemircumcision (Anaes.) (Assist.) Fee: \$291.90 Benefit: 75% = \$218.95
37369	URETHRA, excision of prolapse of (Anaes.) Fee: \$168.50 Benefit: 75% = \$126.40
37372	URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.) Fee: \$421.15 Benefit: 75% = \$315.90
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) Fee: \$1,045.60 Benefit: 75% = \$784.20
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) Fee: \$669.65 Benefit: 75% = \$502.25
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) Fee: \$1,045.60 Benefit: 75% = \$784.20
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) Fee: \$291.90 Benefit: 75% = \$218.95
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
37393	PRIAPISM, decompression by glanular stab cavernospongiosum shunt or penile aspiration with or without lavage (Anaes.) Fee: \$207.60 Benefit: 75% = \$155.70 85% = \$176.50
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) Fee: \$669.65 Benefit: 75% = \$502.25
37402	PENIS, partial amputation of (Anaes.) (Assist.) Fee: \$421.15 Benefit: 75% = \$315.90
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) Fee: \$421.15 Benefit: 75% = \$315.90
37411	PENIS, repair of avulsion (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30 85% = \$769.85
37415	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months Fee: \$42.10 Benefit: 75% = \$31.60 85% = \$35.80
37417	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes.) (Assist.) Fee: \$504.00 Benefit: 75% = \$378.00
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: \$669.65 Benefit: 75% = \$502.25 85% = \$604.45
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: \$330.90 Benefit: 75% = \$248.20
37423	PENIS, lengthening by translocation of corpora (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30

OPERATIONS		UROLOGICAL
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) Fee: \$880.10 Benefit: 75% = \$660.10	
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) Fee: \$291.90 Benefit: 75% = \$218.95	
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30	
37435	PENIS, frenuloplasty as an independent procedure (Anaes.) Fee: \$84.25 Benefit: 75% = \$63.20 85% = \$71.65	
37438	SCROTUM, partial excision of (Anaes.) (Assist.) Fee: \$249.80 Benefit: 75% = \$187.35 85% = \$212.35	
37444	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.) Fee: \$902.75 Benefit: 75% = \$677.10 85% = \$837.55	
OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES		
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) Fee: \$249.80 Benefit: 75% = \$187.35 85% = \$212.35	
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: \$249.80 Benefit: 75% = \$187.35 85% = \$212.35	
† 37605	TRANSCUTANEOUS SPERM RETRIEVAL, unilateral, from either the testis or the epididymis, for the purposes of INTRACYTOPLASMIC SPERM INJECTION, in a man with male factor infertility, excluding a service to which item 13218 applies. (Anaes.) <i>(See para T8.62 of explanatory notes to this Category)</i> Fee: \$337.25 Benefit: 75% = \$252.95 85% = \$286.70	
† 37606	OPEN SURGICAL SPERM RETRIEVAL, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of INTRACYTOPLASMIC SPERM INJECTION, in a man with male factor infertility, performed in a hospital, excluding a service to which item 13218 or 37604 applies. (Anaes.) <i>(See para T8.63 of explanatory notes to this Category)</i> Fee: \$500.80 Benefit: 75% = \$375.60 85% = \$435.60	
37607	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (Anaes.) (Assist.) Fee: \$835.05 Benefit: 75% = \$626.30	
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: \$1,256.35 Benefit: 75% = \$942.30	
37613	EPIDIDYMECTOMY (Anaes.) Fee: \$249.80 Benefit: 75% = \$187.35 85% = \$212.35	
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: \$624.40 Benefit: 75% = \$468.30	
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: \$249.80 Benefit: 75% = \$187.35 85% = \$212.35	

OPERATIONS		UROLOGICAL	
	VASOTOMY OR VASECTOMY, unilateral or bilateral		
	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.) (See para T8.51 of explanatory notes to this Category)		
37622 G	Fee: \$174.50	Benefit: 75% = \$130.90	85% = \$148.35
37623 S	Fee: \$207.60	Benefit: 75% = \$155.70	85% = \$176.50
PAEDIATRIC GENTURINARY SURGERY			
37800	PATENT URACHUS, excision of (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05		
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05		
37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Anaes.) (Assist.) Fee: \$543.85 Benefit: 75% = \$407.90 85% = \$478.65		
37809	UNDESCENDED TESTIS, revision orchidopexy for (Anaes.) (Assist.) Fee: \$543.85 Benefit: 75% = \$407.90		
37812	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803 to 37809 applies (Anaes.) (Assist.) Fee: \$502.15 Benefit: 75% = \$376.65		
37815	HYPOSPADIAS, examination under anaesthesia with erection test (Anaes.) Fee: \$83.70 Benefit: 75% = \$62.80		
37818	HYPOSPADIAS, glanuloplasty incorporating meatal advancement (Anaes.) (Assist.) Fee: \$443.85 Benefit: 75% = \$332.90 85% = \$378.65		
37821	HYPOSPADIAS, distal, 1 stage repair (Anaes.) (Assist.) Fee: \$752.35 Benefit: 75% = \$564.30		
37824	HYPOSPADIAS, proximal, 1 stage repair (Anaes.) (Assist.) Fee: \$1,046.05 Benefit: 75% = \$784.55		
37827	HYPOSPADIAS, staged repair, first stage (Anaes.) (Assist.) Fee: \$481.85 Benefit: 75% = \$361.40		
37830	HYPOSPADIAS, staged repair, second stage (Anaes.) (Assist.) Fee: \$624.40 Benefit: 75% = \$468.30 85% = \$559.20		
37833	HYPOSPADIAS, repair of post operative urethral fistula (Anaes.) (Assist.) Fee: \$298.00 Benefit: 75% = \$223.50		
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) Fee: \$627.70 Benefit: 75% = \$470.80		
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) Fee: \$711.25 Benefit: 75% = \$533.45		
37842	EXSTROPHY OF BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) Fee: \$1,380.95 Benefit: 75% = \$1,035.75		
37845	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.) Fee: \$627.70 Benefit: 75% = \$470.80		
37848	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) Fee: \$1,129.75 Benefit: 75% = \$847.35		

OPERATIONS		CARDIO-THORACIC
37851	CONGENITAL ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) Fee: \$836.95 Benefit: 75% = \$627.75	
37854	URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.) Fee: \$330.90 Benefit: 75% = \$248.20	
SUBGROUP 6 - CARDIO-THORACIC		
CARDIOLOGY PROCEDURES		
‡ 38200	RIGHT HEART CATHETERISATION, with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress test (Anaes.) Fee: \$402.25 Benefit: 75% = \$301.70 85% = \$341.95	
‡ 38203	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) Fee: \$480.00 Benefit: 75% = \$360.00 85% = \$414.80	
‡ 38206	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) Fee: \$580.35 Benefit: 75% = \$435.30 85% = \$515.15	
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 T8.64 of explanatory notes to this Category)</i> Fee: \$745.10 Benefit: 75% = \$558.85 85% = \$679.90	
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 T8.64 of explanatory notes to this Category)</i> Fee: \$1,239.45 Benefit: 75% = \$929.60 85% = \$1,174.25	
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: \$369.10 Benefit: 75% = \$276.85 85% = \$313.75	
38215	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) <i>(See para T8.57 of explanatory notes to this Category)</i> Fee: \$400.60 Benefit: 75% = \$300.45 85% = \$340.55	
38218	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) <i>(See para T8.57 of explanatory notes to this Category)</i> Fee: \$600.90 Benefit: 75% = \$450.70 85% = \$535.70	
38220	SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) <i>(See para T8.57 of explanatory notes to this Category)</i> Fee: \$200.30 Benefit: 75% = \$150.25 85% = \$170.30	
38222	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) <i>(See para T8.57 of explanatory notes to this Category)</i> Fee: \$400.60 Benefit: 75% = \$300.45 85% = \$340.55	

OPERATIONS		CARDIO-THORACIC	
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.)</p> <p><i>(See para T8.57 of explanatory notes to this Category)</i></p>	Fee: \$600.95	Benefit: 75% = \$450.75 85% = \$535.75
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.)</p> <p><i>(See para T8.57 of explanatory notes to this Category)</i></p>	Fee: \$801.30	Benefit: 75% = \$601.00 85% = \$736.10
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.)</p> <p><i>(See para T8.57 of explanatory notes to this Category)</i></p>	Fee: \$1,001.55	Benefit: 75% = \$751.20 85% = \$936.35
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.)</p> <p><i>(See para T8.57 of explanatory notes to this Category)</i></p>	Fee: \$801.20	Benefit: 75% = \$600.90 85% = \$736.00
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.)</p> <p><i>(See para T8.57 of explanatory notes to this Category)</i></p>	Fee: \$1,001.50	Benefit: 75% = \$751.15 85% = \$936.30
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 T8.57 of explanatory notes to this Category)</i></p>	Fee: \$1,201.75	Benefit: 75% = \$901.35 85% = \$1,136.55
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>	Fee: \$424.15	Benefit: 75% = \$318.15 85% = \$360.55
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 T8.57 of explanatory notes to this Category)</i></p>	Fee: \$400.60	Benefit: 75% = \$300.45 85% = \$340.55
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 T8.57 of explanatory notes to this Category)</i></p>	Fee: \$1,001.50	Benefit: 75% = \$751.15 85% = \$936.30
38256	<p>TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.)</p>	Fee: \$241.30	Benefit: 75% = \$181.00 85% = \$205.15

OPERATIONS		CARDIO-THORACIC
38270	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.) Fee: \$823.90 Benefit: 75% = \$617.95 85% = \$758.70	
38272	ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.) Fee: \$823.90 Benefit: 75% = \$617.95 85% = \$758.70	
38275	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.) Fee: \$269.30 Benefit: 75% = \$202.00 85% = \$228.95	
38285	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where: - a diagnosis has not been achieved through all other available cardiac investigations; and - a neurogenic cause is not suspected; and - it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death. including initial programming and testing, as an admitted patient in an approved hospital (Anaes.) <i>(See para T8.65 of explanatory notes to this Category)</i> Fee: \$174.20 Benefit: 75% = \$130.65 85% = \$148.10	
38286	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital (Anaes.) Fee: \$156.90 Benefit: 75% = \$117.70 85% = \$133.40	
CATHETER BASED ARRHYTHMIA ABLATION		
38287	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.) Fee: \$1,895.00 Benefit: 75% = \$1,421.25 85% = \$1,829.80	
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.) Fee: \$2,413.00 Benefit: 75% = \$1,809.75	
38293	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.) Fee: \$2,590.05 Benefit: 75% = \$1,942.55 85% = \$2,524.85	
ENDOVASCULAR INTERVENTIONAL PROCEDURES		
38300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) Fee: \$465.45 Benefit: 75% = \$349.10 85% = \$400.25	
38303	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes.) (Assist.) Fee: \$596.75 Benefit: 75% = \$447.60 85% = \$531.55	
38306	TRANSLUMINAL INSERTION OF STENT OR STENTS into 1 occlusion site, including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare (Anaes.) (Assist.) <i>(See para T8.66 of explanatory notes to this Category)</i> Fee: \$688.50 Benefit: 75% = \$516.40 85% = \$623.30	
38309	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) <i>(See para T8.46 of explanatory notes to this Category)</i> Fee: \$799.65 Benefit: 75% = \$599.75 85% = \$734.45	

OPERATIONS	CARDIO-THORACIC
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.) <i>(See para T8.46 of explanatory notes to this Category)</i></p> <p>Fee: \$1,022.65 Benefit: 75% = \$767.00 85% = \$957.45</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.) <i>(See para T8.46 of explanatory notes to this Category)</i></p> <p>Fee: \$1,098.00 Benefit: 75% = \$823.50 85% = \$1,032.80</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.) <i>(See para T8.46 of explanatory notes to this Category)</i></p> <p>Fee: \$1,432.60 Benefit: 75% = \$1,074.45 85% = \$1,367.40</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.) <i>(See para T8.45 of explanatory notes to this Category)</i></p> <p>Fee: \$698.20 Benefit: 75% = \$523.65 85% = \$633.00</p>
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.) <i>(See para T8.45 of explanatory notes to this Category)</i></p> <p>Fee: \$930.20 Benefit: 75% = \$697.65 85% = \$865.00</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.) <i>(See para T8.45 of explanatory notes to this Category)</i></p> <p>Fee: \$1,032.35 Benefit: 75% = \$774.30 85% = \$967.15</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.) <i>(See para T8.45 of explanatory notes to this Category)</i></p> <p>Fee: \$1,265.10 Benefit: 75% = \$948.85 85% = \$1,199.90</p>

OPERATIONS	CARDIO-THORACIC
MISCELLANEOUS CARDIAC PROCEDURES	
38350	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of (Anaes.) Fee: \$576.80 Benefit: 75% = \$432.60
38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy (Anaes.) <i>(See para T8.64 of explanatory notes to this Category)</i> Fee: \$230.70 Benefit: 75% = \$173.05
38356	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of (Anaes.) <i>(See para T8.64 of explanatory notes to this Category)</i> Fee: \$756.20 Benefit: 75% = \$567.15
38358	Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Anaes.) (Assist.) <i>(See para T8.68 of explanatory notes to this Category)</i> Fee: \$2,590.05 Benefit: 75% = \$1,942.55
38359	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.) Fee: \$120.65 Benefit: 75% = \$90.50 85% = \$102.60
38362	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.) Fee: \$347.60 Benefit: 75% = \$260.70 85% = \$295.50
38365	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: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) <i>(See para T8.67 of explanatory notes to this Category)</i> Fee: \$230.70 Benefit: 75% = \$173.05
38368	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: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. 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.) <i>(See para T8.67 of explanatory notes to this Category)</i> Fee: \$1,105.90 Benefit: 75% = \$829.45
38371	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: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) <i>(See para T8.69 of explanatory notes to this Category)</i> Fee: \$259.95 Benefit: 75% = \$195.00 85% = \$221.00
38384	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: - 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. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) Fee: \$950.65 Benefit: 75% = \$713.00 85% = \$885.45

OPERATIONS	CARDIO-THORACIC
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: \$259.95 Benefit: 75% = \$195.00 85% = \$221.00</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: \$950.65 Benefit: 75% = \$713.00 85% = \$885.45</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: \$259.95 Benefit: 75% = \$195.00 85% = \$221.00</p>
THORACIC SURGERY	
38415	<p>EMPHYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.)</p> <p>Fee: \$360.60 Benefit: 75% = \$270.45 85% = \$306.55</p>
38418	<p>THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.)</p> <p>Fee: \$865.55 Benefit: 75% = \$649.20</p>
38421	<p>THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.)</p> <p>Fee: \$1,383.55 Benefit: 75% = \$1,037.70</p>
38424	<p>THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.)</p> <p>Fee: \$865.55 Benefit: 75% = \$649.20</p>
38427	<p>THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.)</p> <p>Fee: \$1,068.70 Benefit: 75% = \$801.55</p>
38430	<p>THORACOPLASTY (in stages) each stage (Anaes.) (Assist.)</p> <p>Fee: \$550.80 Benefit: 75% = \$413.10</p>
38436	<p>THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.)</p> <p>Fee: \$225.55 Benefit: 75% = \$169.20</p>
38438	<p>PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes.) (Assist.)</p> <p>Fee: \$1,383.55 Benefit: 75% = \$1,037.70</p>
38440	<p>LUNG, wedge resection of (Anaes.) (Assist.)</p> <p>Fee: \$1,036.00 Benefit: 75% = \$777.00</p>
38441	<p>RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.)</p> <p>Fee: \$1,639.25 Benefit: 75% = \$1,229.45</p>
38446	<p>THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.)</p> <p>Fee: \$1,068.70 Benefit: 75% = \$801.55</p>
38447	<p>PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.)</p> <p>Fee: \$1,383.55 Benefit: 75% = \$1,037.70</p>
38448	<p>MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.)</p> <p>Fee: \$327.85 Benefit: 75% = \$245.90</p>

OPERATIONS		CARDIO-THORACIC
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,935.50 Benefit: 75% = \$1,451.65	
38450	PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.) Fee: \$773.65 Benefit: 75% = \$580.25	
38452	PERICARDIUM, sub-xyphoid drainage of (Anaes.) (Assist.) Fee: \$518.10 Benefit: 75% = \$388.60	
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,554.10 Benefit: 75% = \$1,165.60	
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$2,102.10 Benefit: 75% = \$1,576.60	
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: \$1,383.55 Benefit: 75% = \$1,037.70	
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.) Fee: \$1,291.65 Benefit: 75% = \$968.75	
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.) Fee: \$688.50 Benefit: 75% = \$516.40	
38460	STERNAL WIRE OR WIRES, removal of (Anaes.) Fee: \$248.70 Benefit: 75% = \$186.55	
38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes.) Fee: \$294.75 Benefit: 75% = \$221.10	
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: \$320.40 Benefit: 75% = \$240.30	
38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.) Fee: \$865.15 Benefit: 75% = \$648.90	
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.) Fee: \$1,333.15 Benefit: 75% = \$999.90	
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.) Fee: \$1,554.10 Benefit: 75% = \$1,165.60	
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: \$865.55 Benefit: 75% = \$649.20	
38473	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.) Fee: \$518.10 Benefit: 75% = \$388.60	
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: \$751.15 Benefit: 75% = \$563.40	

OPERATIONS		CARDIO-THORACIC
38477	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.) Fee: \$1,809.20 Benefit: 75% = \$1,356.90	
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.) Fee: \$876.40 Benefit: 75% = \$657.30	
38480	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.) Fee: \$1,809.20 Benefit: 75% = \$1,356.90	
38481	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.) Fee: \$2,059.65 Benefit: 75% = \$1,544.75	
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: \$1,554.10 Benefit: 75% = \$1,165.60	
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) Fee: \$737.95 Benefit: 75% = \$553.50	
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) Fee: \$1,554.10 Benefit: 75% = \$1,165.60	
38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.) Fee: \$1,724.50 Benefit: 75% = \$1,293.40	
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.) Fee: \$2,050.95 Benefit: 75% = \$1,538.25	
38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.) Fee: \$500.80 Benefit: 75% = \$375.60	
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) Fee: \$1,767.90 Benefit: 75% = \$1,325.95	
SURGERY FOR ISCHAEMIC HEART DISEASE		
<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>		
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.) Fee: \$563.50 Benefit: 75% = \$422.65	
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 T8.72 of explanatory notes to this Category)</i> Fee: \$1,849.10 Benefit: 75% = \$1,386.85	
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 T8.72 of explanatory notes to this Category)</i> Fee: \$1,849.10 Benefit: 75% = \$1,386.85	
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 T8.72 of explanatory notes to this Category)</i> Fee: \$1,986.75 Benefit: 75% = \$1,490.10	

OPERATIONS	CARDIO-THORACIC
38501	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass , using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38503, 38504 or 38600 apply (Anaes.) (Assist.) (See para T8.72 of explanatory notes to this Category) Fee: \$1,986.75 Benefit: 75% = \$1,490.10
38503	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Anaes.) (Assist.) (See para T8.72 of explanatory notes to this Category) Fee: \$2,157.20 Benefit: 75% = \$1,617.90
38504	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass , using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Anaes.) (Assist.) (See para T8.72 of explanatory notes to this Category) Fee: \$2,157.20 Benefit: 75% = \$1,617.90
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.) (Assist.) Fee: \$250.40 Benefit: 75% = \$187.80
38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.) Fee: \$1,468.65 Benefit: 75% = \$1,101.50
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.) Fee: \$1,724.15 Benefit: 75% = \$1,293.15
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.) Fee: \$2,157.20 Benefit: 75% = \$1,617.90
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.) Fee: \$2,157.20 Benefit: 75% = \$1,617.90
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: \$1,895.00 Benefit: 75% = \$1,421.25
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: \$2,413.00 Benefit: 75% = \$1,809.75
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.) Fee: \$2,590.05 Benefit: 75% = \$1,942.55
PROCEDURES ON 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: \$1,938.15 Benefit: 75% = \$1,453.65
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) Fee: \$2,456.15 Benefit: 75% = \$1,842.15

OPERATIONS	CARDIO-THORACIC
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) Fee: \$2,803.80 Benefit: 75% = \$2,102.85
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) Fee: \$2,285.70 Benefit: 75% = \$1,714.30
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: \$2,803.80 Benefit: 75% = \$2,102.85
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: \$3,144.70 Benefit: 75% = \$2,358.55
38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endvascular means (Anaes.) (Assist.) Fee: \$1,682.35 Benefit: 75% = \$1,261.80
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,852.90 Benefit: 75% = \$1,389.70
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.) Fee: \$1,794.50 Benefit: 75% = \$1,345.90
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.) Fee: \$500.80 Benefit: 75% = \$375.60
TECHNIQUES FOR PRESERVATION OF 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: \$375.70 Benefit: 75% = \$281.80
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: \$1,383.55 Benefit: 75% = \$1,037.70
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes.) (Assist.) Fee: \$865.55 Benefit: 75% = \$649.20
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.) Fee: \$432.70 Benefit: 75% = \$324.55
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.) Fee: \$485.05 Benefit: 75% = \$363.80 85% = \$419.85
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.) Fee: \$608.80 Benefit: 75% = \$456.60
38615	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) Fee: \$1,383.55 Benefit: 75% = \$1,037.70
38618	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) Fee: \$1,724.50 Benefit: 75% = \$1,293.40

OPERATIONS		CARDIO-THORACIC
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) Fee: \$688.50 Benefit: 75% = \$516.40	
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) Fee: \$773.65 Benefit: 75% = \$580.25	
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: \$604.65 Benefit: 75% = \$453.50	
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: \$500.80 Benefit: 75% = \$375.60	
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 T8.73 of explanatory notes to this Category)</i> Fee: \$865.55 Benefit: 75% = \$649.20	
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: \$963.90 Benefit: 75% = \$722.95	
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75	
38650	MYOMECTIONY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.) Fee: \$1,724.50 Benefit: 75% = \$1,293.40	
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$1,724.50 Benefit: 75% = \$1,293.40	
38654	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: - 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.) <i>(See para T8.67 of explanatory notes to this Category)</i> Fee: \$1,105.90 Benefit: 75% = \$829.45	
38656	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.) Fee: \$865.55 Benefit: 75% = \$649.20	
CARDIAC TUMOURS		
<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>		
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.) Fee: \$1,724.15 Benefit: 75% = \$1,293.15	
38673	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.) Fee: \$1,940.60 Benefit: 75% = \$1,455.45	

OPERATIONS		CARDIO-THORACIC
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.) Fee: \$1,815.50 Benefit: 75% = \$1,361.65	
38680	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.) Fee: \$2,153.45 Benefit: 75% = \$1,615.10 85% = \$2,088.25	
CONGENITAL CARDIAC 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>		
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$963.90 Benefit: 75% = \$722.95	
38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,737.60 Benefit: 75% = \$1,303.20	
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,645.80 Benefit: 75% = \$1,234.35	
38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75	
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.) Fee: \$2,314.75 Benefit: 75% = \$1,736.10	
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,540.90 Benefit: 75% = \$1,155.70	
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75	
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,350.80 Benefit: 75% = \$1,013.10	
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75	
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: \$1,350.80 Benefit: 75% = \$1,013.10	
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: \$1,927.65 Benefit: 75% = \$1,445.75	
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,350.80 Benefit: 75% = \$1,013.10	
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75	
38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,737.60 Benefit: 75% = \$1,303.20	
38742	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,737.60 Benefit: 75% = \$1,303.20	
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75	

OPERATIONS		CARDIO-THORACIC	
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75		
38751	VENTRICULAR SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75		
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) Fee: \$2,413.00 Benefit: 75% = \$1,809.75		
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75		
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75		
38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75		
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,927.65 Benefit: 75% = \$1,445.75		
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: \$34.80 Benefit: 75% = \$26.10 85% = \$29.60		
38803	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample Fee: \$69.40 Benefit: 75% = \$52.05 85% = \$59.00		
38806	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.) Fee: \$120.65 Benefit: 75% = \$90.50 85% = \$102.60		
38809	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.) Fee: \$148.65 Benefit: 75% = \$111.50 85% = \$126.40		
38812	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) Fee: \$188.90 Benefit: 75% = \$141.70 85% = \$160.60		
SUBGROUP 7 - NEUROSURGICAL			
GENERAL			
39000	LUMBAR PUNCTURE (Anaes.) Fee: \$68.00 Benefit: 75% = \$51.00 85% = \$57.80		
39003	CISTERNAL PUNCTURE (Anaes.) Fee: \$77.35 Benefit: 75% = \$58.05 85% = \$65.75		
39006	VENTRICULAR PUNCTURE (not including burr-hole) (Anaes.) Fee: \$144.00 Benefit: 75% = \$108.00 85% = \$122.40		
39009	SUBDURAL HAEMORRHAGE, tap for, each tap (Anaes.) Fee: \$53.60 Benefit: 75% = \$40.20		
39012	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.) Fee: \$214.55 Benefit: 75% = \$160.95		
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: \$98.60 Benefit: 75% = \$73.95 85% = \$83.85		
39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.) (Assist.) Fee: \$339.55 Benefit: 75% = \$254.70		

OPERATIONS		NEUROSURGICAL
39018	CEREBROSPINAL FLUID reservoir, insertion of (Anaes.) (Assist.) Fee: \$339.55 Benefit: 75% = \$254.70	
PAIN RELIEF		
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) Fee: \$214.55 Benefit: 75% = \$160.95 85% = \$182.40	
39106	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.) Fee: \$1,073.05 Benefit: 75% = \$804.80	
39109	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.) Fee: \$400.70 Benefit: 75% = \$300.55 85% = \$340.60	
39112	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$1,392.15 Benefit: 75% = \$1,044.15	
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: \$68.00 Benefit: 75% = \$51.00 85% = \$57.80	
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.) Fee: \$268.95 Benefit: 75% = \$201.75 85% = \$228.65	
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) Fee: \$570.55 Benefit: 75% = \$427.95 85% = \$505.35	
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) Fee: \$1,460.10 Benefit: 75% = \$1,095.10	
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: \$269.15 Benefit: 75% = \$201.90	
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: \$326.85 Benefit: 75% = \$245.15	
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic intractable pain (Anaes.) Fee: \$427.75 Benefit: 75% = \$320.85	
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: \$596.00 Benefit: 75% = \$447.00	
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: \$608.85 Benefit: 75% = \$456.65	
39131	ELECTRODES, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris - each day Fee: \$115.45 Benefit: 75% = \$86.60 85% = \$98.15	
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: \$144.00 Benefit: 75% = \$108.00	
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: \$307.60 Benefit: 75% = \$230.70	

OPERATIONS	NEUROSURGICAL
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 (Anaes.) Fee: \$144.00 Benefit: 75% = \$108.00 85% = \$122.40
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 (Anaes.) Fee: \$144.00 Benefit: 75% = \$108.00
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: \$546.70 Benefit: 75% = \$410.05
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: \$608.85 Benefit: 75% = \$456.65
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: \$817.35 Benefit: 75% = \$613.05
39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) Fee: \$264.45 Benefit: 75% = \$198.35 85% = \$224.80
PERIPHERAL NERVES	
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$319.10 Benefit: 75% = \$239.35
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$420.90 Benefit: 75% = \$315.70
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$611.25 Benefit: 75% = \$458.45
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$645.10 Benefit: 75% = \$483.85
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$359.90 Benefit: 75% = \$269.95
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) Fee: \$930.35 Benefit: 75% = \$697.80
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.) Fee: \$577.25 Benefit: 75% = \$432.95
39321	NERVE, transposition of (Anaes.) (Assist.) Fee: \$427.75 Benefit: 75% = \$320.85
39323	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.) Fee: \$249.95 Benefit: 75% = \$187.50 85% = \$212.50
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.) Fee: \$249.95 Benefit: 75% = \$187.50 85% = \$212.50
+ 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: \$427.85 Benefit: 75% = \$320.90 85% = \$363.70
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.) Fee: \$249.95 Benefit: 75% = \$187.50

OPERATIONS		NEUROSURGICAL
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.) Fee: \$249.95 Benefit: 75% = \$187.50 85% = \$212.50	
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$359.90 Benefit: 75% = \$269.95 85% = \$305.95	
CRANIAL NERVES		
39500	VESTIBULAR NERVE, section of, via posterior fossa (Anaes.) (Assist.) Fee: \$1,147.75 Benefit: 75% = \$860.85	
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.) Fee: \$862.40 Benefit: 75% = \$646.80	
CRANIO-CEREBRAL INJURIES		
39600	INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes (Anaes.) (Assist.) Fee: \$427.75 Benefit: 75% = \$320.85	
39603	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes.) (Assist.) Fee: \$1,079.80 Benefit: 75% = \$809.85	
39606	FRACTURED SKULL, depressed or comminuted, operation for (Anaes.) (Assist.) Fee: \$719.85 Benefit: 75% = \$539.90	
39609	FRACTURED SKULL, compound, without dural penetration, operation for (Anaes.) (Assist.) Fee: \$862.40 Benefit: 75% = \$646.80	
39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.) (Assist.) Fee: \$1,011.90 Benefit: 75% = \$758.95	
39615	FRACTURED SKULL with rhinorrhoea or otorrhoea, cranioplasty and repair of (Anaes.) (Assist.) Fee: \$1,079.80 Benefit: 75% = \$809.85	
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 T8.74 of explanatory notes to this Category)</i> Fee: \$2,737.85 Benefit: 75% = \$2,053.40	
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 T8.74 of explanatory notes to this Category)</i> Fee: \$2,878.35 Benefit: 75% = \$2,158.80	
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 T8.74 of explanatory notes to this Category)</i> Fee: \$3,299.50 Benefit: 75% = \$2,474.65	
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 T8.74 of explanatory notes to this Category)</i> Fee: \$2,386.80 Benefit: 75% = \$1,790.10	
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 T8.74 of explanatory notes to this Category)</i> Fee: \$4,247.30 Benefit: 75% = \$3,185.50	
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 T8.74 of explanatory notes to this Category)</i> Fee: \$3,088.95 Benefit: 75% = \$2,316.75	

OPERATIONS	NEUROSURGICAL
39656	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure) conjoint surgery, co-surgeon (Assist.) (See para T8.74 of explanatory notes to this Category) Fee: \$2,316.65 Benefit: 75% = \$1,737.50
39658	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.) (Assist.) (See para T8.74 of explanatory notes to this Category) Fee: \$2,737.85 Benefit: 75% = \$2,053.40
39660	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.) (See para T8.74 of explanatory notes to this Category) Fee: \$2,737.85 Benefit: 75% = \$2,053.40
39662	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.) (See para T8.74 of explanatory notes to this Category) Fee: \$2,737.85 Benefit: 75% = \$2,053.40
INTRA-CRANIAL NEOPLASMS	
39700	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes.) (Assist.) Fee: \$502.65 Benefit: 75% = \$377.00
39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes.) (Assist.) Fee: \$468.60 Benefit: 75% = \$351.45
39706	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes.) (Assist.) Fee: \$1,005.00 Benefit: 75% = \$753.75
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: \$1,432.95 Benefit: 75% = \$1,074.75
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: \$2,587.30 Benefit: 75% = \$1,940.50
39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (Anaes.) (Assist.) Fee: \$1,792.90 Benefit: 75% = \$1,344.70
39718	ARACHNOIDAL CYST, craniotomy for (Anaes.) (Assist.) Fee: \$787.75 Benefit: 75% = \$590.85
39721	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes.) (Assist.) Fee: \$719.85 Benefit: 75% = \$539.90
CEREBROVASCULAR DISEASE	
39800	ANEURYSM, clipping or reinforcement of sac (Anaes.) (Assist.) Fee: \$2,580.60 Benefit: 75% = \$1,935.45
39803	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.) Fee: \$2,580.60 Benefit: 75% = \$1,935.45
39806	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.) Fee: \$1,161.20 Benefit: 75% = \$870.90
39812	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.) (Assist.) Fee: \$570.55 Benefit: 75% = \$427.95
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.) Fee: \$1,650.15 Benefit: 75% = \$1,237.65 85% = \$1,584.95
39818	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.) Fee: \$1,650.15 Benefit: 75% = \$1,237.65

OPERATIONS		NEUROSURGICAL
39821	EXTRACRANIAL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.) Fee: \$1,959.50 Benefit: 75% = \$1,469.65	
INFECTION		
39900	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.) Fee: \$468.60 Benefit: 75% = \$351.45	
39903	INTRACRANIAL ABSCESS, excision of (Anaes.) (Assist.) Fee: \$1,432.95 Benefit: 75% = \$1,074.75	
39906	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.) Fee: \$719.85 Benefit: 75% = \$539.90	
CEREBROSPINAL FLUID CIRCULATION DISORDERS		
40000	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.) Fee: \$828.50 Benefit: 75% = \$621.40	
40003	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.) Fee: \$828.50 Benefit: 75% = \$621.40	
40006	LUMBAR SHUNT DIVERSION, insertion of (Anaes.) (Assist.) Fee: \$651.95 Benefit: 75% = \$489.00	
40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.) Fee: \$475.35 Benefit: 75% = \$356.55	
40012	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.) (Assist.) Fee: \$930.35 Benefit: 75% = \$697.80	
40015	SUBTEMPORAL DECOMPRESSION (Anaes.) (Assist.) Fee: \$576.80 Benefit: 75% = \$432.60	
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.) Fee: \$144.00 Benefit: 75% = \$108.00 85% = \$122.40	
CONGENITAL DISORDERS		
40100	MENINGOCELE, excision and closure of (Anaes.) (Assist.) Fee: \$624.75 Benefit: 75% = \$468.60	
40103	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (Anaes.) (Assist.) Fee: \$916.85 Benefit: 75% = \$687.65	
40106	ARNOLD-CHIARI MALFORMATION, decompression of (Anaes.) (Assist.) Fee: \$930.35 Benefit: 75% = \$697.80	
40109	ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.) Fee: \$1,005.00 Benefit: 75% = \$753.75	
40112	TETHERED CORD, release of, including lipomeningocele or diastematomyelia (Anaes.) (Assist.) Fee: \$1,290.25 Benefit: 75% = \$967.70	
40115	CRANIOSTENOSIS, operation for - single suture (Anaes.) (Assist.) Fee: \$651.95 Benefit: 75% = \$489.00	
40118	CRANIOSTENOSIS, operation for - more than 1 suture (Anaes.) (Assist.) Fee: \$862.40 Benefit: 75% = \$646.80	
SPINAL DISORDERS		
40300	INTERVERTEBRAL DISC OR DISCS, partial or total laminectomy for removal of (Anaes.) (Assist.) Fee: \$862.40 Benefit: 75% = \$646.80	
40301	INTERVERTEBRAL DISC OR DISCS, microsurgical partial or total discectomy of (Anaes.) (Assist.) Fee: \$865.15 Benefit: 75% = \$648.90	

OPERATIONS	NEUROSURGICAL
40303	RECURRENT DISC LESION OR SPINAL STENOSIS, or both, partial or total laminectomy for - 1 level (Anaes.) (Assist.) Fee: \$984.65 Benefit: 75% = \$738.50
40306	SPINAL STENOSIS, partial or total laminectomy for, involving more than 1 vertebral interspace (disc level) (Anaes.) (Assist.) Fee: \$1,297.05 Benefit: 75% = \$972.80
40309	EEXTRADURAL TUMOUR OR ABSCESS, partial or total laminectomy for (Anaes.) (Assist.) Fee: \$984.65 Benefit: 75% = \$738.50
40312	INTRADURAL LESION, partial or total laminectomy for, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$1,324.20 Benefit: 75% = \$993.15
40315	CRANIOCERVICAL JUNCTION LESION, transoral approach for (Anaes.) (Assist.) Fee: \$1,432.95 Benefit: 75% = \$1,074.75
40316	ODONTOID screw fixation (Anaes.) (Assist.) Fee: \$1,878.15 Benefit: 75% = \$1,408.65
40318	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, partial or total laminectomy and radical excision of (Anaes.) (Assist.) Fee: \$1,792.90 Benefit: 75% = \$1,344.70
40321	POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (Anaes.) (Assist.) Fee: \$984.65 Benefit: 75% = \$738.50
40324	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – laminectomy, including aftercare (Anaes.) (Assist.) Fee: \$577.25 Benefit: 75% = \$432.95
40327	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – posterior fusion, including aftercare (Assist.) Fee: \$577.25 Benefit: 75% = \$432.95
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: \$862.40 Benefit: 75% = \$646.80
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: \$862.40 Benefit: 75% = \$646.80
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: \$1,407.30 Benefit: 75% = \$1,055.50
40333	CERVICAL PARTIAL OR TOTAL DISCECTOMY (ANTERIOR), without fusion (Anaes.) (Assist.) Fee: \$719.85 Benefit: 75% = \$539.90
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: \$951.70 Benefit: 75% = \$713.80
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: \$1,747.95 Benefit: 75% = \$1,311.00
40336	INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCASE) - 1 disc (Anaes.) (Assist.) <i>(See para T8.75 of explanatory notes to this Category)</i> Fee: \$285.30 Benefit: 75% = \$214.00
40339	HYDROMYELIA, plugging of obex for, with or without duroplasty (Anaes.) (Assist.) Fee: \$1,432.95 Benefit: 75% = \$1,074.75
40342	HYDROMYELIA, craniotomy and partial or total laminectomy for, with cavity packing and CSF shunt (Anaes.) (Assist.) Fee: \$1,324.20 Benefit: 75% = \$993.15

OPERATIONS	NEUROSURGICAL
40345	THORACIC DECOMPRESSION of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Anaes.) (Assist.) Fee: \$1,232.75 Benefit: 75% = \$924.60
40348	THORACIC DECOMPRESSION of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes.) (Assist.) Fee: \$1,565.10 Benefit: 75% = \$1,173.85
40351	THORACO-LUMBAR or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Anaes.) (Assist.) Fee: \$1,565.10 Benefit: 75% = \$1,173.85
SKULL RECONSTRUCTION	
40600	CRANIOPLASTY, reconstructive (Anaes.) (Assist.) Fee: \$862.40 Benefit: 75% = \$646.80
EPILEPSY	
40700	CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes.) (Assist.) Fee: \$1,575.55 Benefit: 75% = \$1,181.70
40703	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.) Fee: \$1,324.20 Benefit: 75% = \$993.15
40706	HEMISPHERECTOMY for intractable epilepsy (Anaes.) (Assist.) Fee: \$1,935.40 Benefit: 75% = \$1,451.55 85% = \$1,870.20
40709	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes.) (Assist.) Fee: \$468.60 Benefit: 75% = \$351.45
40712	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes.) (Assist.) Fee: \$943.90 Benefit: 75% = \$707.95
STEREOTACTIC PROCEDURES	
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes.) (Assist.) Fee: \$576.80 Benefit: 75% = \$432.60 85% = \$511.60
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: \$1,576.60 Benefit: 75% = \$1,182.45
40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes.) (Assist.) Fee: \$1,079.80 Benefit: 75% = \$809.85 85% = \$1,014.60
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: \$2,045.05 Benefit: 75% = \$1,533.80
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: \$3,578.95 Benefit: 75% = \$2,684.25
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: \$307.60 Benefit: 75% = \$230.70
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: \$475.35 Benefit: 75% = \$356.55

OPERATIONS	EAR, NOSE AND THROAT
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.) Fee: \$864.50 Benefit: 75% = \$648.40
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) Fee: \$1,033.45 Benefit: 75% = \$775.10
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) Fee: \$1,157.50 Benefit: 75% = \$868.15
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) Fee: \$984.30 Benefit: 75% = \$738.25
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.) Fee: \$1,078.50 Benefit: 75% = \$808.90
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) Fee: \$624.75 Benefit: 75% = \$468.60
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.) Fee: \$1,438.65 Benefit: 75% = \$1,079.00
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.) Fee: \$1,695.00 Benefit: 75% = \$1,271.25
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.) Fee: \$984.30 Benefit: 75% = \$738.25
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.) Fee: \$1,078.50 Benefit: 75% = \$808.90
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) Fee: \$1,335.15 Benefit: 75% = \$1,001.40
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: \$1,726.55 Benefit: 75% = \$1,294.95
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.) Fee: \$984.30 Benefit: 75% = \$738.25
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.) Fee: \$1,078.50 Benefit: 75% = \$808.90
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) Fee: \$933.05 Benefit: 75% = \$699.80
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: \$2,199.65 Benefit: 75% = \$1,649.75
41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.) Fee: \$3,299.50 Benefit: 75% = \$2,474.65
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$2,199.65 Benefit: 75% = \$1,649.75
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) Fee: \$1,649.70 Benefit: 75% = \$1,237.30

OPERATIONS		EAR, NOSE AND THROAT
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) Fee: \$2,530.00 Benefit: 75% = \$1,897.50	
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) Fee: \$1,736.30 Benefit: 75% = \$1,302.25	
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) Fee: \$2,364.75 Benefit: 75% = \$1,773.60	
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) Fee: \$1,078.50 Benefit: 75% = \$808.90	
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) Fee: \$1,405.65 Benefit: 75% = \$1,054.25	
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) Fee: \$1,570.90 Benefit: 75% = \$1,178.20	
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) Fee: \$1,570.90 Benefit: 75% = \$1,178.20	
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: \$455.05 Benefit: 75% = \$341.30 85% = \$389.85	
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: \$168.45 Benefit: 75% = \$126.35 85% = \$143.20	
41608	STAPEDECTOMY (Anaes.) (Assist.) Fee: \$984.30 Benefit: 75% = \$738.25	
41611	STAPES MOBILISATION (Anaes.) (Assist.) Fee: \$633.30 Benefit: 75% = \$475.00	
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.) Fee: \$984.30 Benefit: 75% = \$738.25 85% = \$919.10	
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: \$984.30 Benefit: 75% = \$738.25 85% = \$919.10	
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.) Fee: \$1,711.55 Benefit: 75% = \$1,283.70	
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) Fee: \$744.65 Benefit: 75% = \$558.50	
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) Fee: \$1,078.50 Benefit: 75% = \$808.90	
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.) Fee: \$130.05 Benefit: 75% = \$97.55 85% = \$110.55	

OPERATIONS		EAR, NOSE AND THROAT
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05	
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.) Fee: \$215.70 Benefit: 75% = \$161.80 85% = \$183.35	
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.) Fee: \$1,033.45 Benefit: 75% = \$775.10 85% = \$968.25	
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.) Fee: \$1,289.90 Benefit: 75% = \$967.45	
41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) Fee: \$42.85 Benefit: 75% = \$32.15 85% = \$36.45	
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) Fee: \$128.95 Benefit: 75% = \$96.75 85% = \$109.65	
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.) Fee: \$99.25 Benefit: 75% = \$74.45 85% = \$84.40	
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: \$99.25 Benefit: 75% = \$74.45 85% = \$84.40	
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: \$64.95 Benefit: 75% = \$48.75 85% = \$55.25	
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) Fee: \$110.95 Benefit: 75% = \$83.25 85% = \$94.35	
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) Fee: \$70.05 Benefit: 75% = \$52.55 85% = \$59.55	
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of <i>(See para T8.79 of explanatory notes to this Category)</i> Fee: \$74.50 Benefit: 75% = \$55.90 85% = \$63.35	
41665 G 41668 S	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes.) <i>(See para T8.79 of explanatory notes to this Category)</i> Fee: \$155.80 Benefit: 75% = \$116.85 Fee: \$198.65 Benefit: 75% = \$149.00	
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.) Fee: \$436.45 Benefit: 75% = \$327.35	
41672	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) Fee: \$544.45 Benefit: 75% = \$408.35	
41674	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) Fee: \$90.75 Benefit: 75% = \$68.10 85% = \$77.15	
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) Fee: \$81.25 Benefit: 75% = \$60.95 85% = \$69.10	
41680	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) Fee: \$147.15 Benefit: 75% = \$110.40 85% = \$125.10	

OPERATIONS		EAR, NOSE AND THROAT
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: \$105.80 Benefit: 75% = \$79.35 85% = \$89.95	
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: \$64.95 Benefit: 75% = \$48.75 85% = \$55.25	
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.) Fee: \$123.25 Benefit: 75% = \$92.45	
41692	TURBINATES, submucous resection of, unilateral (Anaes.) Fee: \$160.75 Benefit: 75% = \$120.60	
41695	TURBINATES, cryotherapy to (Anaes.) Fee: \$90.30 Benefit: 75% = \$67.75 85% = \$76.80	
41698	MAXILLARY ANTRUM, PNOSE PUNCTURE AND LAVAGE OF (Anaes.) Fee: \$29.35 Benefit: 75% = \$22.05 85% = \$24.95	
41701	MAXILLARY ANTRUM, pnose 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: \$83.05 Benefit: 75% = \$62.30	
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) Fee: \$32.80 Benefit: 75% = \$24.60 85% = \$27.90	
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.) Fee: \$405.05 Benefit: 75% = \$303.80	
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05	
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.) Fee: \$547.75 Benefit: 75% = \$410.85	
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) Fee: \$267.00 Benefit: 75% = \$200.25	
41719	ANTRUM, drainage of, through tooth socket (Anaes.) Fee: \$106.15 Benefit: 75% = \$79.65 85% = \$90.25	
41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00 85% = \$465.45	
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.) Fee: \$405.05 Benefit: 75% = \$303.80	
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.) Fee: \$810.35 Benefit: 75% = \$607.80	
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.) Fee: \$513.55 Benefit: 75% = \$385.20	
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.) Fee: \$701.80 Benefit: 75% = \$526.35	
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.) Fee: \$915.80 Benefit: 75% = \$686.85	
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.) Fee: \$436.45 Benefit: 75% = \$327.35	
41740	FRONTAL SINUS, catheterisation of (Anaes.) Fee: \$53.10 Benefit: 75% = \$39.85	

OPERATIONS		EAR, NOSE AND THROAT	
41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.) Fee: \$304.75 Benefit: 75% = \$228.60		
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.) Fee: \$701.80 Benefit: 75% = \$526.35 85% = \$636.60		
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.) Fee: \$547.75 Benefit: 75% = \$410.85		
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.) Fee: \$267.00 Benefit: 75% = \$200.25		
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) Fee: \$42.00 Benefit: 75% = \$31.50 85% = \$35.70		
41758	DIVISION OF PHARYNGEAL ADHESIONS (Anaes.) Fee: \$106.15 Benefit: 75% = \$79.65 85% = \$90.25		
41761	POSTNASAL SPACE, direct examination of, with or without biopsy (Anaes.) Fee: \$110.95 Benefit: 75% = \$83.25 85% = \$94.35		
41764	NASENOSCOPY or SINOSCOPY or FIBROPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures, unilateral or bilateral examination (Anaes.) Fee: \$110.95 Benefit: 75% = \$83.25 85% = \$94.35		
41767	NASOPHARYNGEAL ANGIOFIBROMA, transpalatal removal (Anaes.) (Assist.) Fee: \$665.55 Benefit: 75% = \$499.20 85% = \$600.35		
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) Fee: \$633.30 Benefit: 75% = \$475.00		
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohman's operation) (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00		
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.) Fee: \$529.20 Benefit: 75% = \$396.90		
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) Fee: \$633.30 Benefit: 75% = \$475.00		
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.) Fee: \$859.80 Benefit: 75% = \$644.85 85% = \$794.60		
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.) Fee: \$1,066.65 Benefit: 75% = \$800.00		
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) Fee: \$665.55 Benefit: 75% = \$499.20		
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: \$513.55 Benefit: 75% = \$385.20 85% = \$448.35		
41788 G 41789 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes.) Fee: \$198.65 Benefit: 75% = \$149.00 Fee: \$267.00 Benefit: 75% = \$200.25		
41792 G 41793 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes.) Fee: \$249.95 Benefit: 75% = \$187.50 Fee: \$335.50 Benefit: 75% = \$251.65		
41796 G 41797 S	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) Fee: \$102.70 Benefit: 75% = \$77.05 Fee: \$130.05 Benefit: 75% = \$97.55		

OPERATIONS		EAR, NOSE AND THROAT	
41800 G 41801 S	ADENOIDS, removal of (Anaes.) Fee: \$106.15 Fee: \$147.15	Benefit: 75% = \$79.65 Benefit: 75% = \$110.40	
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.) Fee: \$81.25	Benefit: 75% = \$60.95	
41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) Fee: \$63.30	Benefit: 75% = \$47.50	85% = \$53.85
41810	UVULOTOMY or UVULECTOMY (Anaes.) Fee: \$32.15	Benefit: 75% = \$24.15	85% = \$27.35
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) Fee: \$321.85	Benefit: 75% = \$241.40	
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.) Fee: \$167.65	Benefit: 75% = \$125.75	85% = \$142.55
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: \$315.15	Benefit: 75% = \$236.40	85% = \$267.90
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: \$378.20	Benefit: 75% = \$283.65	85% = \$321.50
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.) Fee: \$215.70	Benefit: 75% = \$161.80	
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.) Fee: \$321.85	Benefit: 75% = \$241.40	
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) Fee: \$47.15	Benefit: 75% = \$35.40	85% = \$40.10
41831	OESOPHAGUS, endoscopic pneumatic dilatation of (Anaes.) (Assist.) Fee: \$322.45	Benefit: 75% = \$241.85	85% = \$274.10
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) Fee: \$206.35	Benefit: 75% = \$154.80	85% = \$175.40
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.) Fee: \$1,164.15	Benefit: 75% = \$873.15	
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.) Fee: \$1,116.25	Benefit: 75% = \$837.20	
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.) Fee: \$1,372.50	Benefit: 75% = \$1,029.40	
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) Fee: \$1,206.95	Benefit: 75% = \$905.25	
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 T8.80 of explanatory notes to this Category)</i> Fee: \$167.65	Benefit: 75% = \$125.75	85% = \$142.55
41849	LARYNX, direct examination of, with biopsy (Anaes.) (Assist.) Fee: \$246.45	Benefit: 75% = \$184.85	
41852	LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) Fee: \$267.00	Benefit: 75% = \$200.25	

OPERATIONS		EAR, NOSE AND THROAT	
41855	MICROLARYNGOSCOPY (Anaes.) (Assist.) Fee: \$260.30 Benefit: 75% = \$195.25		
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.) <i>(See para T8.81 of explanatory notes to this Category)</i> Fee: \$446.30 Benefit: 75% = \$334.75		
41861	MICROLARYNGOSCOPY with removal of papillomata by laser surgery (Anaes.) (Assist.) Fee: \$545.70 Benefit: 75% = \$409.30		
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) Fee: \$368.00 Benefit: 75% = \$276.00		
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.) Fee: \$553.90 Benefit: 75% = \$415.45		
41868	LARYNGEAL WEB, division of, using microlaryngoscopic techniques (Anaes.) Fee: \$351.05 Benefit: 75% = \$263.30		
41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.) Fee: \$410.75 Benefit: 75% = \$308.10		
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00 85% = \$465.45		
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00 85% = \$465.45		
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.) Fee: \$859.80 Benefit: 75% = \$644.85		
41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.) Fee: \$229.50 Benefit: 75% = \$172.15		
41881	TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.) (Assist.) Fee: \$362.75 Benefit: 75% = \$272.10		
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) Fee: \$82.20 Benefit: 75% = \$61.65		
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) Fee: \$260.00 Benefit: 75% = \$195.00 85% = \$221.00		
41886	TRACHEA, removal of foreign body in (Anaes.) Fee: \$160.75 Benefit: 75% = \$120.60 85% = \$136.65		
41889	BRONCHOSCOPY, as an independent procedure (Anaes.) Fee: \$160.75 Benefit: 75% = \$120.60 85% = \$136.65		
41892	BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) Fee: \$212.25 Benefit: 75% = \$159.20 85% = \$180.45		
41895	BRONCHUS, removal of foreign body in (Anaes.) (Assist.) Fee: \$332.10 Benefit: 75% = \$249.10		
41898	FIBREOPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.) Fee: \$232.05 Benefit: 75% = \$174.05 85% = \$197.25		
41901	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.) Fee: \$545.70 Benefit: 75% = \$409.30		

OPERATIONS		OPHTHALMOLOGY
41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.) Fee: \$222.60 Benefit: 75% = \$166.95 85% = \$189.25	
41905	TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) Fee: \$409.45 Benefit: 75% = \$307.10	
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) Fee: \$110.95 Benefit: 75% = \$83.25 85% = \$94.35	
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) Fee: \$352.40 Benefit: 75% = \$264.30	
SUBGROUP 9 - OPHTHALMOLOGY		
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$92.55 Benefit: 75% = \$69.45	
42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) Fee: \$434.60 Benefit: 75% = \$325.95 85% = \$369.45	
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) Fee: \$550.05 Benefit: 75% = \$412.55	
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) Fee: \$634.00 Benefit: 75% = \$475.50	
42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.) Fee: \$434.60 Benefit: 75% = \$325.95 85% = \$369.45	
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) Fee: \$550.05 Benefit: 75% = \$412.55	
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: \$319.10 Benefit: 75% = \$239.35	
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) Fee: \$1,086.60 Benefit: 75% = \$814.95	
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.) Fee: \$184.75 Benefit: 75% = \$138.60 85% = \$157.05	
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) Fee: \$366.70 Benefit: 75% = \$275.05	
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) Fee: \$570.55 Benefit: 75% = \$427.95	
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) Fee: \$366.70 Benefit: 75% = \$275.05	
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) Fee: \$753.70 Benefit: 75% = \$565.30	
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) Fee: \$1,073.05 Benefit: 75% = \$804.80	
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) Fee: \$455.05 Benefit: 75% = \$341.30	
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) Fee: \$798.15 Benefit: 75% = \$598.65	

OPERATIONS	OPHTHALMOLOGY
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: \$1,154.45 Benefit: 75% = \$865.85
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) Fee: \$685.85 Benefit: 75% = \$514.40
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: \$570.55 Benefit: 75% = \$427.95 85% = \$505.35
42554	EYEBALL, PERFORATING WOUND OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) Fee: \$665.55 Benefit: 75% = \$499.20
42557	EYEBALL, PERFORATING WOUND OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) Fee: \$930.35 Benefit: 75% = \$697.80
42560	INTRAOCULAR FOREIGN BODY, magnetic removal from anterior segment (Anaes.) (Assist.) Fee: \$366.70 Benefit: 75% = \$275.05 85% = \$311.70
42563	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from anterior segment (Anaes.) (Assist.) Fee: \$468.60 Benefit: 75% = \$351.45 85% = \$403.40
42566	INTRAOCULAR FOREIGN BODY, magnetic removal from posterior segment (Anaes.) (Assist.) Fee: \$665.55 Benefit: 75% = \$499.20
42569	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from posterior segment (Anaes.) (Assist.) Fee: \$930.35 Benefit: 75% = \$697.80
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) Fee: \$105.95 Benefit: 75% = \$79.50 85% = \$90.10
42573	DERMOID, periorbital, excision of (Anaes.) Fee: \$205.40 Benefit: 75% = \$154.05 85% = \$174.60
42574	DERMOID, orbital, excision of (Anaes.) (Assist.) Fee: \$436.45 Benefit: 75% = \$327.35 85% = \$371.25
42575	TARSAL CYST, extirpation of (Anaes.) Fee: \$74.75 Benefit: 75% = \$56.10 85% = \$63.55
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) Fee: \$105.95 Benefit: 75% = \$79.50 85% = \$90.10
42584	TARSORRHAPHY (Anaes.) (Assist.) Fee: \$249.95 Benefit: 75% = \$187.50 85% = \$212.50
42587	TRICHIASIS, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) Fee: \$46.90 Benefit: 75% = \$35.20 85% = \$39.90
42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) Fee: \$305.55 Benefit: 75% = \$229.20 85% = \$259.75
42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes.) Fee: \$184.75 Benefit: 75% = \$138.60
42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) Fee: \$455.05 Benefit: 75% = \$341.30 85% = \$389.85
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.) Fee: \$570.55 Benefit: 75% = \$427.95 85% = \$505.35
42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) Fee: \$570.55 Benefit: 75% = \$427.95 85% = \$505.35

OPERATIONS		OPHTHALMOLOGY	
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) Fee: \$420.90 Benefit: 75% = \$315.70 85% = \$357.80		
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) Fee: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90		
42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) Fee: \$86.90 Benefit: 75% = \$65.20 85% = \$73.90		
42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) Fee: \$130.35 Benefit: 75% = \$97.80 85% = \$110.80		
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: \$43.60 Benefit: 75% = \$32.70 85% = \$37.10		
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: \$65.20 Benefit: 75% = \$48.90 85% = \$55.45		
42617	PUNCTUM SNIP operation (Anaes.) Fee: \$123.65 Benefit: 75% = \$92.75 85% = \$105.15		
42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) Fee: \$47.55 Benefit: 75% = \$35.70 85% = \$40.45		
42621	PUNCTUM, temporary occlusion of, by use of electrical cautery (Anaes.) Fee: \$47.55 Benefit: 75% = \$35.70 85% = \$40.45		
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) Fee: \$74.75 Benefit: 75% = \$56.10 85% = \$63.55		
42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) Fee: \$631.65 Benefit: 75% = \$473.75		
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.) Fee: \$1,018.70 Benefit: 75% = \$764.05 85% = \$953.50		
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.) Fee: \$767.35 Benefit: 75% = \$575.55		
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) Fee: \$105.95 Benefit: 75% = \$79.50 85% = \$90.10		
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) Fee: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90		
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) Fee: \$339.55 Benefit: 75% = \$254.70 85% = \$288.65		
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) Fee: \$441.40 Benefit: 75% = \$331.05 85% = \$376.20		
42644	CORNEA OR SCLERA, removal of imbedded foreign body from (excluding aftercare) (Anaes.) <i>(See para T8.82 of explanatory notes to this Category)</i> Fee: \$65.10 Benefit: 75% = \$48.85 85% = \$55.35		
42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) Fee: \$184.75 Benefit: 75% = \$138.60 85% = \$157.05		
42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.) Fee: \$65.10 Benefit: 75% = \$48.85 85% = \$55.35		

OPERATIONS		OPHTHALMOLOGY
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) Fee: \$145.20 Benefit: 75% = \$108.90 85% = \$123.45	
42653	CORNEA, transplantation of, full thickness (Anaes.) (Assist.) Fee: \$1,208.75 Benefit: 75% = \$906.60	
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) Fee: \$1,507.65 Benefit: 75% = \$1,130.75	
42659	CORNEA, transplantation of, superficial or lamellar (Anaes.) (Assist.) Fee: \$814.90 Benefit: 75% = \$611.20 85% = \$749.70	
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) Fee: \$814.90 Benefit: 75% = \$611.20	
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.) Fee: \$543.30 Benefit: 75% = \$407.50 85% = \$478.10	
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: \$128.20 Benefit: 75% = \$96.15 85% = \$109.00	
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) Fee: \$68.00 Benefit: 75% = \$51.00 85% = \$57.80	
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 T8.83 of explanatory notes to this Category)</i> Fee: \$814.90 Benefit: 75% = \$611.20 85% = \$749.70	
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: \$407.40 Benefit: 75% = \$305.55 85% = \$346.30	
42676	CONJUNCTIVA, biopsy of, as an independent procedure Fee: \$104.50 Benefit: 75% = \$78.40 85% = \$88.85	
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) Fee: \$55.05 Benefit: 75% = \$41.30 85% = \$46.80	
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO ² or N ² O (Anaes.) Fee: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90	
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) Fee: \$108.70 Benefit: 75% = \$81.55	
42686	PTERYGIUM, removal of (Anaes.) Fee: \$247.15 Benefit: 75% = \$185.40 85% = \$210.10	
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) Fee: \$105.95 Benefit: 75% = \$79.50 85% = \$90.10	
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) Fee: \$249.95 Benefit: 75% = \$187.50 85% = \$212.50	
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) Fee: \$407.40 Benefit: 75% = \$305.55 85% = \$346.30	
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: \$635.65 Benefit: 75% = \$476.75 85% = \$570.45	
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: \$354.45 Benefit: 75% = \$265.85 85% = \$301.30	

OPERATIONS	OPHTHALMOLOGY
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: \$812.90 Benefit: 75% = \$609.70 85% = \$747.70
42703	ARTIFICIAL LENS, insertion of, into the posterior chamber and suture to the iris and sclera (Anaes.) (Assist.) Fee: \$516.60 Benefit: 75% = \$387.45 85% = \$451.40
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: \$420.90 Benefit: 75% = \$315.70 85% = \$357.80
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: \$719.85 Benefit: 75% = \$539.90 85% = \$654.65
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: \$814.90 Benefit: 75% = \$611.20 85% = \$749.70
42713	INTRAOCULAR LENSES, repositioning of, by the use of a McCannell suture or similar (Anaes.) (Assist.) Fee: \$339.55 Benefit: 75% = \$254.70 85% = \$288.65
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) Fee: \$1,079.80 Benefit: 75% = \$809.85 85% = \$1,014.60
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: \$468.60 Benefit: 75% = \$351.45 85% = \$403.40
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: \$512.65 Benefit: 75% = \$384.50
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: \$1,208.75 Benefit: 75% = \$906.60
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: \$203.80 Benefit: 75% = \$152.85
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 T8.84 of explanatory notes to this Category)</i> Fee: \$1,371.75 Benefit: 75% = \$1,028.85
42734	CAPSULOTOMY, other than by laser (Anaes.) (Assist.) Fee: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90
42737	NEEDLING OF POSTERIOR CAPSULE (Anaes.) (Assist.) Fee: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90
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: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) Fee: \$570.55 Benefit: 75% = \$427.95 85% = \$505.35
42744	NEEDLING FOR DRAINAGE OF ENCYSTED BLEB, following trabeculectomy (Anaes.) Fee: \$271.40 Benefit: 75% = \$203.55 85% = \$230.70
42746	GLAUCOMA, filtering operation for (Anaes.) (Assist.) Fee: \$862.40 Benefit: 75% = \$646.80

OPERATIONS		OPHTHALMOLOGY	
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) Fee: \$1,079.80 Benefit: 75% = \$809.85		
42752	GLAUCOMA, insertion of Molteno valve for, 1 or more stages (Anaes.) (Assist.) Fee: \$1,208.75 Benefit: 75% = \$906.60		
42755	GLAUCOMA, removal of Molteno valve (Anaes.) Fee: \$149.40 Benefit: 75% = \$112.05 85% = \$127.00		
42758	GONIOTOMY (Anaes.) (Assist.) Fee: \$631.65 Benefit: 75% = \$473.75		
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) Fee: \$468.60 Benefit: 75% = \$351.45 85% = \$403.40		
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) Fee: \$468.60 Benefit: 75% = \$351.45 85% = \$403.40		
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) Fee: \$984.65 Benefit: 75% = \$738.50		
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 T8.85 of explanatory notes to this Category)</i> Fee: \$266.30 Benefit: 75% = \$199.75 85% = \$226.40		
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 T8.85 of explanatory notes to this Category)</i> Fee: \$262.15 Benefit: 75% = \$196.65 85% = \$222.85		
42773	DETACHED RETINA, diathermy or cryotherapy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) Fee: \$814.90 Benefit: 75% = \$611.20 85% = \$749.70		
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) Fee: \$1,208.75 Benefit: 75% = \$906.60		
42779	DETACHED RETINA, revision operation for (Anaes.) (Assist.) Fee: \$1,507.65 Benefit: 75% = \$1,130.75		
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 T8.86 of explanatory notes to this Category)</i> Fee: \$407.40 Benefit: 75% = \$305.55 85% = \$346.30		
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 T8.86 of explanatory notes to this Category)</i> Fee: \$407.40 Benefit: 75% = \$305.55 85% = \$346.30		
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 T8.87 of explanatory notes to this Category)</i> Fee: \$319.10 Benefit: 75% = \$239.35 85% = \$271.25		
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 T8.87 of explanatory notes to this Category)</i> Fee: \$319.10 Benefit: 75% = \$239.35 85% = \$271.25		
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 T8.88 of explanatory notes to this Category)</i> Fee: \$319.10 Benefit: 75% = \$239.35 85% = \$271.25		

OPERATIONS	OPHTHALMOLOGY
42789	<p>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 T8.88 of explanatory notes to this Category)</i> Fee: \$319.10 Benefit: 75% = \$239.35 85% = \$271.25</p>
42791	<p>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 T8.89 of explanatory notes to this Category)</i> Fee: \$319.10 Benefit: 75% = \$239.35 85% = \$271.25</p>
42792	<p>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 T8.89 of explanatory notes to this Category)</i> Fee: \$319.10 Benefit: 75% = \$239.35 85% = \$271.25</p>
42794	<p>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.) <i>(See para T8.90 of explanatory notes to this Category)</i> Fee: \$61.10 Benefit: 75% = \$45.85 85% = \$51.95</p>
42797	<p>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.) <i>(See para T8.91 of explanatory notes to this Category)</i> Fee: \$61.10 Benefit: 75% = \$45.85 85% = \$51.95</p>
42801	<p>EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.) Fee: \$948.00 Benefit: 75% = \$711.00</p>
42802	<p>EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.) Fee: \$473.80 Benefit: 75% = \$355.35</p>
42805	<p>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: \$529.60 Benefit: 75% = \$397.20 85% = \$464.40</p>
42806	<p>IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) Fee: \$319.10 Benefit: 75% = \$239.35 85% = \$271.25</p>
42807	<p>PHOTOMYDRIASIS, laser Fee: \$321.30 Benefit: 75% = \$241.00 85% = \$273.15</p>
42808	<p>PHOTOIRIDOSYNERESIS, laser Fee: \$321.30 Benefit: 75% = \$241.00 85% = \$273.15</p>
42809	<p>RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) Fee: \$407.40 Benefit: 75% = \$305.55 85% = \$346.30</p>
42810	<p>PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) Fee: \$512.70 Benefit: 75% = \$384.55 85% = \$447.50</p>
42811	<p>TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) Fee: \$407.40 Benefit: 75% = \$305.55 85% = \$346.30</p>
42812	<p>DETACHED RETINA, removal of encircling silicone band from (Anaes.) Fee: \$149.40 Benefit: 75% = \$112.05 85% = \$127.00</p>
42815	<p>POSTERIOR CHAMBER, removal of silicone oil from (Anaes.) (Assist.) Fee: \$570.55 Benefit: 75% = \$427.95</p>
42818	<p>RETINA, CRYOTHERAPY TO, as an independent procedure, with external probe (Anaes.) Fee: \$529.60 Benefit: 75% = \$397.20 85% = \$464.40</p>

OPERATIONS		OSTEOMYELITIS
+ † 43022	Photodynamic therapy, both eyes, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation. Fee: \$493.20 Benefit: 75% = \$369.90 85% = \$428.00	
+ † 43023	Infusion of Verteporfin for discontinued photodynamic therapy, where a session of therapy which would have been provided under item 43021 or 43022 has been discontinued on medical grounds. Fee: \$79.90 Benefit: 75% = \$59.95 85% = \$67.95	
SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS		
ACUTE		
43500	OPERATION ON PHALANX (Anaes.) Fee: \$111.45 Benefit: 75% = \$83.60	
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.) Fee: \$184.85 Benefit: 75% = \$138.65	
43506	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) Fee: \$321.85 Benefit: 75% = \$241.40	
43509	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) Fee: \$321.85 Benefit: 75% = \$241.40	
CHRONIC		
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: \$321.85 Benefit: 75% = \$241.40	
43515	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) Fee: \$321.85 Benefit: 75% = \$241.40 85% = \$273.60	
43518	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00	
43521	OPERATION ON SKULL (Anaes.) (Assist.) Fee: \$419.50 Benefit: 75% = \$314.65	
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00 85% = \$465.45	
SUBGROUP 11 - PAEDIATRIC		
SURGERY IN NEONATE OR YOUNG CHILD		
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) Fee: \$864.50 Benefit: 75% = \$648.40	
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) Fee: \$920.50 Benefit: 75% = \$690.40	
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.) Fee: \$1,004.20 Benefit: 75% = \$753.15	
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) Fee: \$1,171.65 Benefit: 75% = \$878.75	
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intestinal perforation with or without meconium peritonitis (Anaes.) (Assist.) Fee: \$1,171.65 Benefit: 75% = \$878.75	

OPERATIONS	PAEDIATRIC
43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.) Fee: \$1,087.85 Benefit: 75% = \$815.90
43819	HIRSCHSPRUNG'S DISEASE, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) Fee: \$878.70 Benefit: 75% = \$659.05
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.) Fee: \$878.70 Benefit: 75% = \$659.05
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) Fee: \$1,004.20 Benefit: 75% = \$753.15
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) Fee: \$1,109.50 Benefit: 75% = \$832.15
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) Fee: \$864.50 Benefit: 75% = \$648.40
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) Fee: \$1,004.20 Benefit: 75% = \$753.15
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) Fee: \$1,255.20 Benefit: 75% = \$941.40
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: \$1,087.85 Benefit: 75% = \$815.90
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: \$1,673.70 Benefit: 75% = \$1,255.30
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: \$1,799.15 Benefit: 75% = \$1,349.40
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) Fee: \$460.25 Benefit: 75% = \$345.20
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) Fee: \$1,464.35 Benefit: 75% = \$1,098.30 85% = \$1,399.15
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) Fee: \$1,548.20 Benefit: 75% = \$1,161.15
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) Fee: \$543.85 Benefit: 75% = \$407.90 85% = \$478.65
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) Fee: \$1,506.35 Benefit: 75% = \$1,129.80
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.) Fee: \$1,129.75 Benefit: 75% = \$847.35
43867	GASTROSCHISIS, secondary operation for, with removal of silo and closure of abdominal wall (Anaes.) (Assist.) Fee: \$627.70 Benefit: 75% = \$470.80
43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) Fee: \$878.70 Benefit: 75% = \$659.05

OPERATIONS		PAEDIATRIC
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) Fee: \$1,171.65 Benefit: 75% = \$878.75	
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) Fee: \$1,004.20 Benefit: 75% = \$753.15	
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) Fee: \$1,171.65 Benefit: 75% = \$878.75	
43882	CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.) Fee: \$1,506.35 Benefit: 75% = \$1,129.80 85% = \$1,441.15	
THORACIC SURGERY		
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) Fee: \$1,004.20 Benefit: 75% = \$753.15	
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) Fee: \$1,673.70 Benefit: 75% = \$1,255.30	
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) Fee: \$1,464.35 Benefit: 75% = \$1,098.30	
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) Fee: \$1,464.35 Benefit: 75% = \$1,098.30	
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) Fee: \$1,383.55 Benefit: 75% = \$1,037.70	
43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) Fee: \$1,046.05 Benefit: 75% = \$784.55 85% = \$980.85	
ABDOMINAL SURGERY		
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) Fee: \$402.25 Benefit: 75% = \$301.70	
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) Fee: \$470.85 Benefit: 75% = \$353.15	
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) Fee: \$878.70 Benefit: 75% = \$659.05	
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.) Fee: \$669.50 Benefit: 75% = \$502.15	
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) Fee: \$209.30 Benefit: 75% = \$157.00 85% = \$177.95	
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) Fee: \$878.70 Benefit: 75% = \$659.05	
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) Fee: \$125.60 Benefit: 75% = \$94.20 85% = \$106.80	
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) Fee: \$786.90 Benefit: 75% = \$590.20	
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) Fee: \$962.45 Benefit: 75% = \$721.85	
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) Fee: \$1,046.05 Benefit: 75% = \$784.55	

OPERATIONS		PAEDIATRIC
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.) Fee: \$368.00 Benefit: 75% = \$276.00	
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) Fee: \$1,464.35 Benefit: 75% = \$1,098.30	
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) Fee: \$1,673.70 Benefit: 75% = \$1,255.30	
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) Fee: \$2,301.35 Benefit: 75% = \$1,726.05	
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) Fee: \$1,673.70 Benefit: 75% = \$1,255.30	
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) Fee: \$1,966.65 Benefit: 75% = \$1,475.00	
43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) Fee: \$1,673.70 Benefit: 75% = \$1,255.30	
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) Fee: \$460.25 Benefit: 75% = \$345.20	
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) Fee: \$1,171.65 Benefit: 75% = \$878.75	
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) Fee: \$1,297.15 Benefit: 75% = \$972.90	
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: \$1,590.10 Benefit: 75% = \$1,192.60	
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: \$1,715.60 Benefit: 75% = \$1,286.70 85% = \$1,650.40	
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: \$1,924.80 Benefit: 75% = \$1,443.60 85% = \$1,859.60	
43999	HIRSCHSPRUNG'S DISEASE, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) Fee: \$240.70 Benefit: 75% = \$180.55	
44102	RECTUM, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) Fee: \$232.05 Benefit: 75% = \$174.05	
44105	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, under general anaesthesia (Anaes.) Fee: \$40.75 Benefit: 75% = \$30.60 85% = \$34.65	
44108	INGUINAL HERNIA repair at age less than 3 months (Anaes.) (Assist.) Fee: \$443.85 Benefit: 75% = \$332.90	
44111	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair of, at age less than 3 months, including orchidopexy when performed (Anaes.) (Assist.) Fee: \$519.80 Benefit: 75% = \$389.85 85% = \$454.60	
44114	INGUINAL HERNIA repair at age less than 3 months when orchidopexy also required (Anaes.) (Assist.) Fee: \$519.80 Benefit: 75% = \$389.85	

OPERATIONS	AMPUTATIONS
MISCELLANEOUS SURGERY	
44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) Fee: \$418.40 Benefit: 75% = \$313.80 85% = \$355.65
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) Fee: \$332.10 Benefit: 75% = \$249.10
44136	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15
SUBGROUP 12 - AMPUTATIONS	
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.) Fee: \$267.00 Benefit: 75% = \$200.25 85% = \$226.95
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.) Fee: \$321.85 Benefit: 75% = \$241.40
44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00
44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) Fee: \$1,078.50 Benefit: 75% = \$808.90 85% = \$1,013.30
44338	1 DIGIT of foot, amputation of (Anaes.) Fee: \$130.05 Benefit: 75% = \$97.55 85% = \$110.55
44342	2 DIGITS of 1 foot, amputation of (Anaes.) Fee: \$198.65 Benefit: 75% = \$149.00
44346	3 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) Fee: \$229.35 Benefit: 75% = \$172.05
44350	4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) Fee: \$260.30 Benefit: 75% = \$195.25 85% = \$221.30
44354	5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) Fee: \$297.85 Benefit: 75% = \$223.40
44358	TOE, including metatarsal or part of metatarsal each toe, amputation of (Anaes.) Fee: \$166.05 Benefit: 75% = \$124.55
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: \$238.35 Benefit: 75% = \$178.80
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.) Fee: \$321.85 Benefit: 75% = \$241.40
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.) Fee: \$267.00 Benefit: 75% = \$200.25
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.) Fee: \$471.30 Benefit: 75% = \$353.50
44370	AMPUTATION AT HIP (Anaes.) (Assist.) Fee: \$650.40 Benefit: 75% = \$487.80
44373	HINDQUARTER, amputation of (Anaes.) (Assist.) Fee: \$1,335.15 Benefit: 75% = \$1,001.40 85% = \$1,269.95
44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.) Derived Fee: 75% of the original amputation fee

OPERATIONS		PLASTIC AND RECONSTRUCTIVE	
45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.) Fee: \$108.70 Benefit: 75% = \$81.55 85% = \$92.40		
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: \$116.70 Benefit: 75% = \$87.55 85% = \$99.20		
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) Fee: \$217.35 Benefit: 75% = \$163.05 85% = \$184.75		
45035	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.) Fee: \$634.00 Benefit: 75% = \$475.50		
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.) Fee: \$1,018.70 Benefit: 75% = \$764.05		
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.) Fee: \$217.35 Benefit: 75% = \$163.05 85% = \$184.75		
45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.) Fee: \$278.50 Benefit: 75% = \$208.90 85% = \$236.75		
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) Fee: \$278.50 Benefit: 75% = \$208.90 85% = \$236.75		
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: \$699.45 Benefit: 75% = \$524.60		
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 T8.95 of explanatory notes to this Category)</i> Fee: \$427.85 Benefit: 75% = \$320.90		
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.) <i>(See para T8.96 of explanatory notes to this Category)</i> Fee: \$222.20 Benefit: 75% = \$166.65		
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 T8.97 of explanatory notes to this Category)</i> Fee: \$256.80 Benefit: 75% = \$192.60 85% = \$218.30		
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 T8.97 of explanatory notes to this Category)</i> Fee: \$366.70 Benefit: 75% = \$275.05 85% = \$311.70		
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 T8.97 of explanatory notes to this Category)</i> Fee: \$346.40 Benefit: 75% = \$259.80 85% = \$294.45		
45207	H-FLAP OR DOUBLE ADVANCEMENT FLAP where indicated to repair 1 defect, on eyelid, eyebrow or forehead (Anaes.) Fee: \$346.40 Benefit: 75% = \$259.80 85% = \$294.45		
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.) Fee: \$427.85 Benefit: 75% = \$320.90 85% = \$363.70		
45212	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (Anaes.) Fee: \$212.25 Benefit: 75% = \$159.20 85% = \$180.45		

OPERATIONS		PLASTIC AND RECONSTRUCTIVE	
45215	DIRECT FLAP REPAIR, cross leg, first stage (Anaes.) (Assist.) Fee: \$915.80 Benefit: 75% = \$686.85		
45218	DIRECT FLAP REPAIR, cross leg, second stage (Anaes.) (Assist.) Fee: \$410.75 Benefit: 75% = \$308.10		
45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.) Fee: \$236.15 Benefit: 75% = \$177.15 85% = \$200.75		
45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.) Fee: \$106.15 Benefit: 75% = \$79.65 85% = \$90.25		
45227	INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.) Fee: \$402.25 Benefit: 75% = \$301.70 85% = \$341.95		
45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.) Fee: \$201.10 Benefit: 75% = \$150.85 85% = \$170.95		
45233	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.) Fee: \$427.85 Benefit: 75% = \$320.90 85% = \$363.70		
45236	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.) Fee: \$335.50 Benefit: 75% = \$251.65		
45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.) Fee: \$236.15 Benefit: 75% = \$177.15 85% = \$200.75		
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: \$236.15 Benefit: 75% = \$177.15 85% = \$200.75		
FREE GRAFTS			
45400	FREE GRAFTING (split skin) of a granulating area, small (Anaes.) Fee: \$184.85 Benefit: 75% = \$138.65 85% = \$157.15		
45403	FREE GRAFTING (split skin) of a granulating area, extensive (Anaes.) (Assist.) Fee: \$368.00 Benefit: 75% = \$276.00 85% = \$312.80		
45406	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes.) (Assist.) <i>(See para T8.98 of explanatory notes to this Category)</i> Fee: \$407.40 Benefit: 75% = \$305.55 85% = \$346.30		
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 T8.98 of explanatory notes to this Category)</i> Fee: \$543.30 Benefit: 75% = \$407.50		
45412	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (Anaes.) (Assist.) <i>(See para T8.98 of explanatory notes to this Category)</i> Fee: \$747.10 Benefit: 75% = \$560.35		
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 T8.98 of explanatory notes to this Category)</i> Fee: \$814.90 Benefit: 75% = \$611.20		
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 T8.98 of explanatory notes to this Category)</i> Fee: \$882.80 Benefit: 75% = \$662.10		
45439	FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (Anaes.) Fee: \$256.80 Benefit: 75% = \$192.60 85% = \$218.30		

OPERATIONS	PLASTIC AND RECONSTRUCTIVE
45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.) Fee: \$529.60 Benefit: 75% = \$397.20 85% = \$464.40
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: \$502.65 Benefit: 75% = \$377.00 85% = \$437.45
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: \$339.55 Benefit: 75% = \$254.70 85% = \$288.65
45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.) Fee: \$427.85 Benefit: 75% = \$320.90 85% = \$363.70
45460	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>15 percent or more but less than 20 percent</i> of total body surface - one surgeon (Anaes.) (Assist.) Fee: \$1,131.85 Benefit: 75% = \$848.90
45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>15 percent or more but less than 20 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$806.65 Benefit: 75% = \$605.00
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: \$608.80 Benefit: 75% = \$456.60
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: \$1,727.70 Benefit: 75% = \$1,295.80
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: \$1,230.90 Benefit: 75% = \$923.20 85% = \$1,165.70
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: \$928.30 Benefit: 75% = \$696.25 85% = \$863.10
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: \$1,655.05 Benefit: 75% = \$1,241.30
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: \$1,248.70 Benefit: 75% = \$936.55 85% = \$1,183.50
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: \$2,080.35 Benefit: 75% = \$1,560.30 85% = \$2,015.15
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: \$1,569.20 Benefit: 75% = \$1,176.90 85% = \$1,504.00
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: \$2,504.50 Benefit: 75% = \$1,878.40 85% = \$2,439.30
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: \$1,889.70 Benefit: 75% = \$1,417.30 85% = \$1,824.50
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: \$2,928.75 Benefit: 75% = \$2,196.60 85% = \$2,863.55

OPERATIONS		PLASTIC AND RECONSTRUCTIVE
45478	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 60 percent or more but less than 70 percent of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$2,209.00 Benefit: 75% = \$1,656.75 85% = \$2,143.80	
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$3,352.80 Benefit: 75% = \$2,514.60 85% = \$3,287.60	
45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$2,529.60 Benefit: 75% = \$1,897.20 85% = \$2,464.40	
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$3,820.00 Benefit: 75% = \$2,865.00 85% = \$3,754.80	
45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$2,882.20 Benefit: 75% = \$2,161.65 85% = \$2,817.00	
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: \$476.55 Benefit: 75% = \$357.45	
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: \$407.40 Benefit: 75% = \$305.55	
45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.) Fee: \$366.70 Benefit: 75% = \$275.05 85% = \$311.70	
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.) Fee: \$407.40 Benefit: 75% = \$305.55	
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.) Fee: \$611.25 Benefit: 75% = \$458.45 85% = \$546.05	
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.) Fee: \$815.00 Benefit: 75% = \$611.25	
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.) Fee: \$1,018.70 Benefit: 75% = \$764.05	
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.) Fee: \$1,222.40 Benefit: 75% = \$916.80	
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.) Fee: \$366.70 Benefit: 75% = \$275.05	
45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.) Fee: \$1,479.85 Benefit: 75% = \$1,109.90 85% = \$1,414.65	
OTHER GRAFTS AND MISCELLANEOUS PROCEDURES		
45496	FLAP, free tissue transfer using microvascular techniques - revision of , by open operation (Anaes.) Fee: \$375.70 Benefit: 75% = \$281.80	
45497	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - complete revision of , by liposuction (Anaes.) Fee: \$293.45 Benefit: 75% = \$220.10	
45498	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - staged revision of , by liposuction - first stage (Anaes.) Fee: \$236.15 Benefit: 75% = \$177.15	

OPERATIONS	PLASTIC AND RECONSTRUCTIVE
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: \$176.10 Benefit: 75% = \$132.10
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) Fee: \$984.65 Benefit: 75% = \$738.50
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) Fee: \$1,602.70 Benefit: 75% = \$1,202.05
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) Fee: \$1,602.70 Benefit: 75% = \$1,202.05
45503	MICRO-ARTERIAL OR MICRO-VEINOUS GRAFT using microsurgical techniques (Anaes.) (Assist.) Fee: \$1,833.60 Benefit: 75% = \$1,375.20
45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) Fee: \$1,602.70 Benefit: 75% = \$1,202.05
45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) Fee: \$1,602.70 Benefit: 75% = \$1,202.05
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 where performed by a specialist in the practice of his or her specialty (Anaes.) <i>(See para T8.99 of explanatory notes to this Category)</i> Fee: \$198.65 Benefit: 75% = \$149.00 85% = \$168.90
45512	SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) <i>(See para T8.99 of explanatory notes to this Category)</i> Fee: \$267.00 Benefit: 75% = \$200.25 85% = \$226.95
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 where performed by a specialist in the practice of his or her specialty (Anaes.) <i>(See para T8.99 of explanatory notes to this Category)</i> Fee: \$168.45 Benefit: 75% = \$126.35 85% = \$143.20
45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) <i>(See para T8.99 of explanatory notes to this Category)</i> Fee: \$203.80 Benefit: 75% = \$152.85 85% = \$173.25
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.) Fee: \$387.50 Benefit: 75% = \$290.65
45520	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple (Anaes.) (Assist.) Fee: \$813.15 Benefit: 75% = \$609.90
45522	REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia (Anaes.) (Assist.) <i>(See para T8.100 of explanatory notes to this Category)</i> Fee: \$570.55 Benefit: 75% = \$427.95 85% = \$505.35
45524	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast (Anaes.) (Assist.) <i>(See para T8.101 of explanatory notes to this Category)</i> Fee: \$669.80 Benefit: 75% = \$502.35
45527	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (Anaes.) (Assist.) <i>(See para T8.101 of explanatory notes to this Category)</i> Fee: \$669.80 Benefit: 75% = \$502.35

OPERATIONS	PLASTIC AND RECONSTRUCTIVE
45528	<p>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 T8.101 of explanatory notes to this Category)</i> Fee: \$1,004.55 Benefit: 75% = \$753.45</p>
45530	<p>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 T8.102 of explanatory notes to this Category)</i> Fee: \$992.85 Benefit: 75% = \$744.65</p>
45533	<p>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: \$1,124.45 Benefit: 75% = \$843.35</p>
45536	<p>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: \$413.45 Benefit: 75% = \$310.10</p>
45539	<p>BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) Fee: \$967.45 Benefit: 75% = \$725.60</p>
45542	<p>BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.) Fee: \$553.90 Benefit: 75% = \$415.45</p>
45545	<p>NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.) <i>(See para T8.105 of explanatory notes to this Category)</i> Fee: \$562.15 Benefit: 75% = \$421.65 85% = \$496.95</p>
45546	<p>NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple <i>(See para T8.105 of explanatory notes to this Category)</i> Fee: \$178.70 Benefit: 75% = \$134.05 85% = \$151.90</p>
45548	<p>BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.) Fee: \$249.95 Benefit: 75% = \$187.50 85% = \$212.50</p>
45551	<p>BREAST PROSTHESIS, removal of, with excision of fibrous capsule (Anaes.) (Assist.) Fee: \$400.70 Benefit: 75% = \$300.55</p>
45552	<p>BREAST PROSTHESIS, removal of, with excision of fibrous capsule and replacement of prosthesis (Anaes.) (Assist.) <i>(See para T8.103 of explanatory notes to this Category)</i> Fee: \$576.80 Benefit: 75% = \$432.60 85% = \$511.60</p>
45553	<p>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 T8.103 of explanatory notes to this Category)</i> Fee: \$576.80 Benefit: 75% = \$432.60 85% = \$511.60</p>
45554	<p>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 T8.103 of explanatory notes to this Category)</i> Fee: \$631.65 Benefit: 75% = \$473.75 85% = \$566.45</p>
45555	<p>SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes.) (Assist.) <i>(See para T8.103 of explanatory notes to this Category)</i> Fee: \$576.80 Benefit: 75% = \$432.60</p>
45556	<p>BREAST PTOSIS, correction of (unilateral), to match the position of the contralateral breast (Anaes.) (Assist.) <i>(See para T8.104 of explanatory notes to this Category)</i> Fee: \$691.75 Benefit: 75% = \$518.85 85% = \$626.55</p>

OPERATIONS		PLASTIC AND RECONSTRUCTIVE	
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 <i>where it can be demonstrated</i> that the nipple is inferior to the infra-mammary groove (Anaes.) (Assist.) (See para T8.104 of explanatory notes to this Category)	Fee: \$691.75	Benefit: 75% = \$518.85
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 <i>where it can be demonstrated</i> that the nipple is inferior to the infra-mammary groove (Anaes.) (Assist.) (See para T8.104 of explanatory notes to this Category)	Fee: \$1,037.65	Benefit: 75% = \$778.25
45559	TUBEROUS, TUBULAR OR CONSTRICTED BREAST, where it can be demonstrated , correction of by simultaneous mastopexy and augmentation of (unilateral) (Anaes.) (Assist.) (See para T8.104 of explanatory notes to this Category)	Fee: \$1,026.65	Benefit: 75% = \$770.00 85% = \$961.45
45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.)	Fee: \$427.75	Benefit: 75% = \$320.85 85% = \$363.60
† 45561	MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Anaes.) (Assist.)	Fee: \$1,602.70	Benefit: 75% = \$1,202.05
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: \$992.85	Benefit: 75% = \$744.65 85% = \$927.65
45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)	Fee: \$992.85	Benefit: 75% = \$744.65 85% = \$927.65
‡ 45564	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 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: \$2,299.50	Benefit: 75% = \$1,724.65
‡ 45565	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 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: \$1,724.70	Benefit: 75% = \$1,293.55
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: \$967.45	Benefit: 75% = \$725.60
45568	TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.)	Fee: \$400.70	Benefit: 75% = \$300.55
45569	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: \$611.90	Benefit: 75% = \$458.95
45570	CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.)	Fee: \$826.30	Benefit: 75% = \$619.75 85% = \$761.10
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: \$263.45	Benefit: 75% = \$197.60 85% = \$223.95

OPERATIONS		PLASTIC AND RECONSTRUCTIVE	
45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) Fee: \$650.40 Benefit: 75% = \$487.80 85% = \$585.20		
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) Fee: \$753.25 Benefit: 75% = \$564.95		
45581	FACIAL NERVE PALSY, excision of tissue for (Anaes.) Fee: \$249.95 Benefit: 75% = \$187.50 85% = \$212.50		
45584	LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.) <i>(See para T8.106 of explanatory notes to this Category)</i> Fee: \$570.55 Benefit: 75% = \$427.95 85% = \$505.35		
45585	LIPOSUCTION (suction assisted lipolysis) to 1 regional area, <u>not being a service associated with a service to which item 31521 or 31527 applies, where it can be demonstrated</u> 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 T8.106 of explanatory notes to this Category)</i> Fee: \$570.55 Benefit: 75% = \$427.95 85% = \$505.35		
45586	LIPOSUCTION (suction assisted lipolysis) for reduction of a buffalo hump, <i>where it can be demonstrated that the buffalo hump is secondary to an endocrine disorder or pharmacological treatment of a medical condition</i> (Anaes.) <i>(See para T8.106 of explanatory notes to this Category)</i> Fee: \$570.55 Benefit: 75% = \$427.95		
45587	MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Anaes.) (Assist.) <i>(See para T8.107 of explanatory notes to this Category)</i> Fee: \$804.50 Benefit: 75% = \$603.40 85% = \$739.30		
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.) <i>(See para T8.107 of explanatory notes to this Category)</i> Fee: \$1,206.90 Benefit: 75% = \$905.20		
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.) Fee: \$436.45 Benefit: 75% = \$327.35		
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) Fee: \$512.65 Benefit: 75% = \$384.50		
45596	MAXILLA, total resection of (Anaes.) (Assist.) Fee: \$813.15 Benefit: 75% = \$609.90		
45597	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) Fee: \$1,088.55 Benefit: 75% = \$816.45		
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) Fee: \$845.80 Benefit: 75% = \$634.35 85% = \$780.60		
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) Fee: \$631.65 Benefit: 75% = \$473.75		
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00		
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.) Fee: \$747.10 Benefit: 75% = \$560.35		
45611	MANDIBLE, condylectomy (Anaes.) (Assist.) Fee: \$427.85 Benefit: 75% = \$320.90		
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00 85% = \$465.45		

OPERATIONS		PLASTIC AND RECONSTRUCTIVE	
45653	RHINOPHYMA, shaving of (Anaes.) Fee: \$321.85 Benefit: 75% = \$241.40 85% = \$273.60		
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) Fee: \$453.60 Benefit: 75% = \$340.20 85% = \$388.40		
45659	LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (Anaes.) Fee: \$470.70 Benefit: 75% = \$353.05 85% = \$405.50		
45660	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) Fee: \$2,599.75 Benefit: 75% = \$1,949.85		
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: \$1,155.45 Benefit: 75% = \$866.60		
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.) Fee: \$633.30 Benefit: 75% = \$475.00		
45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.) Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30		
45668	VERMILIONECTOMY, by surgical excision (Anaes.) Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30		
45669	VERMILIONECTOMY, using carbon dioxide laser or erbium laser excision-ablation (Anaes.) <i>(See para T8.111 of explanatory notes to this Category)</i> Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30		
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) Fee: \$753.25 Benefit: 75% = \$564.95 85% = \$688.05		
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) Fee: \$219.05 Benefit: 75% = \$164.30 85% = \$186.20		
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) Fee: \$436.45 Benefit: 75% = \$327.35		
45676	MACROSTOMIA, operation for (Anaes.) (Assist.) Fee: \$519.55 Benefit: 75% = \$389.70		
45677	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$488.90 Benefit: 75% = \$366.70		
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$611.25 Benefit: 75% = \$458.45		
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$679.00 Benefit: 75% = \$509.25		
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$801.45 Benefit: 75% = \$601.10		
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) Fee: \$236.35 Benefit: 75% = \$177.30		
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) Fee: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90		
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) Fee: \$441.40 Benefit: 75% = \$331.05		

OPERATIONS	PLASTIC AND RECONSTRUCTIVE
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.) Fee: \$414.25 Benefit: 75% = \$310.70
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) Fee: \$747.10 Benefit: 75% = \$560.35
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) Fee: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) Fee: \$706.15 Benefit: 75% = \$529.65
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) Fee: \$441.40 Benefit: 75% = \$331.05
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) Fee: \$502.65 Benefit: 75% = \$377.00
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.) Fee: \$706.15 Benefit: 75% = \$529.65
45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) Fee: \$706.15 Benefit: 75% = \$529.65
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 T8.112 of explanatory notes to this Category)</i> Fee: \$873.05 Benefit: 75% = \$654.80 85% = \$807.85
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 T8.112 of explanatory notes to this Category)</i> Fee: \$984.65 Benefit: 75% = \$738.50
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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,112.65 Benefit: 75% = \$834.50
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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,249.55 Benefit: 75% = \$937.20
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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,266.75 Benefit: 75% = \$950.10
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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,426.15 Benefit: 75% = \$1,069.65
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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,454.90 Benefit: 75% = \$1,091.20
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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,636.75 Benefit: 75% = \$1,227.60

OPERATIONS	PLASTIC AND RECONSTRUCTIVE
45741	<p>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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,600.55 Benefit: 75% = \$1,200.45</p>
45744	<p>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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,799.55 Benefit: 75% = \$1,349.70</p>
45747	<p>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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,746.15 Benefit: 75% = \$1,309.65 85% = \$1,680.95</p>
45752	<p>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 T8.112 of explanatory notes to this Category)</i> Fee: \$1,955.85 Benefit: 75% = \$1,466.90</p>
45753	<p>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: \$1,967.50 Benefit: 75% = \$1,475.65 85% = \$1,902.30</p>
45754	<p>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: \$2,358.45 Benefit: 75% = \$1,768.85</p>
45755	<p>TEMPOROMANDIBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.) Fee: \$332.10 Benefit: 75% = \$249.10 85% = \$282.30</p>
45758	<p>TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.) Fee: \$594.30 Benefit: 75% = \$445.75</p>
45761	<p>GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) <i>(See para T8.113 of explanatory notes to this Category)</i> Fee: \$676.10 Benefit: 75% = \$507.10</p>
45767	<p>HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.) Fee: \$2,268.20 Benefit: 75% = \$1,701.15 85% = \$2,203.00</p>
45770	<p>HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.) Fee: \$1,737.45 Benefit: 75% = \$1,303.10</p>
45773	<p>TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.) Fee: \$1,583.45 Benefit: 75% = \$1,187.60 85% = \$1,518.25</p>
45776	<p>ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) Fee: \$1,583.45 Benefit: 75% = \$1,187.60</p>
45779	<p>ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) Fee: \$1,164.15 Benefit: 75% = \$873.15</p>
45782	<p>FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.) Fee: \$890.20 Benefit: 75% = \$667.65 85% = \$825.00</p>
45785	<p>CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.) Fee: \$1,506.40 Benefit: 75% = \$1,129.80</p>

OPERATIONS		PLASTIC AND RECONSTRUCTIVE	
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes.) (Assist.) Fee: \$1,489.25	Benefit: 75% = \$1,116.95	
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.) Fee: \$804.50	Benefit: 75% = \$603.40	
45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.) Fee: \$455.05	Benefit: 75% = \$341.30	85% = \$389.85
45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.) Fee: \$168.45	Benefit: 75% = \$126.35	85% = \$143.20
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: \$26.60	Benefit: 75% = \$19.95	85% = \$22.65
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 T8.114 of explanatory notes to this Category)</i> Fee: \$114.60	Benefit: 75% = \$85.95	85% = \$97.45
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 T8.114 of explanatory notes to this Category)</i> Fee: \$294.45	Benefit: 75% = \$220.85	85% = \$250.30
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 T8.114 of explanatory notes to this Category)</i> Fee: \$155.80	Benefit: 75% = \$116.85	85% = \$132.45
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 T8.114 of explanatory notes to this Category)</i> Fee: \$222.60	Benefit: 75% = \$166.95	85% = \$189.25
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 T8.114 of explanatory notes to this Category)</i> Fee: \$335.50	Benefit: 75% = \$251.65	85% = \$285.20
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 T8.114 of explanatory notes to this Category)</i> Fee: \$453.60	Benefit: 75% = \$340.20	85% = \$388.40
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 T8.114 of explanatory notes to this Category)</i> Fee: \$530.65	Benefit: 75% = \$398.00	85% = \$465.45

OPERATIONS		PLASTIC AND RECONSTRUCTIVE	
45815	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) Fee: \$321.85 Benefit: 75% = \$241.40 85% = \$273.60		
45817	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) Fee: \$419.50 Benefit: 75% = \$314.65 85% = \$356.60		
45819	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.) Fee: \$530.60 Benefit: 75% = \$397.95 85% = \$465.40		
45821	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.) Fee: \$343.85 Benefit: 75% = \$257.90 85% = \$292.30		
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 (Anaes.) Fee: \$98.35 Benefit: 75% = \$73.80 85% = \$83.60		
45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) Fee: \$305.55 Benefit: 75% = \$229.20 85% = \$259.75		
45827	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) Fee: \$292.10 Benefit: 75% = \$219.10 85% = \$248.30		
45829	MAXILLARY TUBEROSITY, reduction of (Anaes.) Fee: \$222.80 Benefit: 75% = \$167.10 85% = \$189.40		
45831	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) Fee: \$292.10 Benefit: 75% = \$219.10 85% = \$248.30		
45833	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) Fee: \$366.70 Benefit: 75% = \$275.05 85% = \$311.70		
45835	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) Fee: \$455.05 Benefit: 75% = \$341.30 85% = \$389.85		
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) Fee: \$529.60 Benefit: 75% = \$397.20 85% = \$464.40		
45839	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) Fee: \$529.60 Benefit: 75% = \$397.20 85% = \$464.40		
45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) Fee: \$427.75 Benefit: 75% = \$320.85 85% = \$363.60		
45843	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) Fee: \$262.35 Benefit: 75% = \$196.80 85% = \$223.00		
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: \$455.05 Benefit: 75% = \$341.30 85% = \$389.85		
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: \$168.45 Benefit: 75% = \$126.35 85% = \$143.20		
45849	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) Fee: \$524.55 Benefit: 75% = \$393.45 85% = \$459.35		
45851	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) Fee: \$129.10 Benefit: 75% = \$96.85 85% = \$109.75		

OPERATIONS		PLASTIC AND RECONSTRUCTIVE	
45853	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) Fee: \$804.50 Benefit: 75% = \$603.40 85% = \$739.30		
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: \$369.10 Benefit: 75% = \$276.85 85% = \$313.75		
45857	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes.) (Assist.) Fee: \$590.40 Benefit: 75% = \$442.80 85% = \$525.20		
45859	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25 85% = \$253.05		
45861	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$787.75 Benefit: 75% = \$590.85 85% = \$722.55		
45863	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$873.25 Benefit: 75% = \$654.95 85% = \$808.05		
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) Fee: \$262.35 Benefit: 75% = \$196.80 85% = \$223.00		
45867	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) Fee: \$282.05 Benefit: 75% = \$211.55 85% = \$239.75		
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: \$1,073.05 Benefit: 75% = \$804.80 85% = \$1,007.85		
45871	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$1,208.75 Benefit: 75% = \$906.60 85% = \$1,143.55		
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: \$1,358.25 Benefit: 75% = \$1,018.70 85% = \$1,293.05		
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: \$425.05 Benefit: 75% = \$318.80 85% = \$361.30		
45877	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) Fee: \$425.05 Benefit: 75% = \$318.80 85% = \$361.30		
45879	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) Fee: \$282.05 Benefit: 75% = \$211.55 85% = \$239.75		
† 45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser. Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00		
† 45885	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Anaes.) (Assist.) Fee: \$400.70 Benefit: 75% = \$300.55 85% = \$340.60		
† 45888	FOREGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) Fee: \$373.45 Benefit: 75% = \$280.10 85% = \$317.45		

OPERATIONS		PLASTIC AND RECONSTRUCTIVE	
† 45891	SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) Fee: \$544.05 Benefit: 75% = \$408.05 85% = \$478.85		
† 45894	FREE GRAFTING, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.) Fee: \$184.85 Benefit: 75% = \$138.65 85% = \$157.15		
† 45897	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) Fee: \$965.50 Benefit: 75% = \$724.15 85% = \$900.30		
† 45900	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity Fee: \$217.80 Benefit: 75% = \$163.35 85% = \$185.15		
† 45903	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) Fee: \$305.55 Benefit: 75% = \$229.20 85% = \$259.75		
† 45906	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) Fee: \$292.10 Benefit: 75% = \$219.10 85% = \$248.30		
† 45909	MAXILLARY TUBEROSITY, reduction of (Anaes.) Fee: \$222.80 Benefit: 75% = \$167.10 85% = \$189.40		
† 45912	PAPILLARY HYPERPLASIA OF THE PALATE, removal of less than 5 lesions (Anaes.) (Assist.) Fee: \$292.10 Benefit: 75% = \$219.10 85% = \$248.30		
† 45915	PAPILLARY HYPERPLASIA OF THE PALATE, removal of 5 to 20 lesions (Anaes.) (Assist.) Fee: \$366.70 Benefit: 75% = \$275.05 85% = \$311.70		
† 45918	PAPILLARY HYPERPLASIA OF THE PALATE, removal of more than 20 lesions (Anaes.) (Assist.) Fee: \$455.05 Benefit: 75% = \$341.30 85% = \$389.85		
† 45921	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) Fee: \$529.60 Benefit: 75% = \$397.20 85% = \$464.40		
† 45924	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) Fee: \$529.60 Benefit: 75% = \$397.20 85% = \$464.40		
† 45939	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) Fee: \$403.75 Benefit: 75% = \$302.85 85% = \$343.20		
† 45945	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) Fee: \$107.25 Benefit: 75% = \$80.45 85% = \$91.20		
† 45975	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting <i>(See para T8.115 of explanatory notes to this Category)</i> Fee: \$116.65 Benefit: 75% = \$87.50 85% = \$99.20		
† 45978	MANDIBLE, treatment of fracture of, not requiring splinting <i>(See para T8.115 of explanatory notes to this Category)</i> Fee: \$142.50 Benefit: 75% = \$106.90 85% = \$121.15		
† 45981	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction <i>(See para T8.115 of explanatory notes to this Category)</i> Fee: \$77.35 Benefit: 75% = \$58.05 85% = \$65.75		
† 45984	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.) <i>(See para T8.115 of explanatory notes to this Category)</i> Fee: \$556.90 Benefit: 75% = \$417.70 85% = \$491.70		
† 45987	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) <i>(See para T8.115 of explanatory notes to this Category)</i> Fee: \$556.90 Benefit: 75% = \$417.70 85% = \$491.70		

OPERATIONS		HAND SURGERY
† 45990	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 T8.115 of explanatory notes to this Category)	Fee: \$760.60 Benefit: 75% = \$570.45 85% = \$695.40
† 45993	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 T8.115 of explanatory notes to this Category)	Fee: \$760.60 Benefit: 75% = \$570.45 85% = \$695.40
† 45996	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) (See para T8.115 of explanatory notes to this Category)	Fee: \$215.70 Benefit: 75% = \$161.80 85% = \$183.35
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: \$305.60 Benefit: 75% = \$229.20
46303	CARPOMETACARPAL JOINT, arthrodesis of (Anaes.) (Assist.)	Fee: \$339.65 Benefit: 75% = \$254.75
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.)	Fee: \$475.45 Benefit: 75% = \$356.60
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.)	Fee: \$475.45 Benefit: 75% = \$356.60
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.)	Fee: \$475.45 Benefit: 75% = \$356.60
46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.)	Fee: \$611.35 Benefit: 75% = \$458.55
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.) (Assist.)	Fee: \$815.05 Benefit: 75% = \$611.30
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.) (Assist.)	Fee: \$1,018.90 Benefit: 75% = \$764.20
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: \$1,222.70 Benefit: 75% = \$917.05 85% = \$1,157.50
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.)	Fee: \$729.10 Benefit: 75% = \$546.85
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: \$760.85 Benefit: 75% = \$570.65
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.)	Fee: \$183.50 Benefit: 75% = \$137.65 85% = \$156.00
46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular repair with or without arthrotomy (Anaes.) (Assist.)	Fee: \$312.55 Benefit: 75% = \$234.45

OPERATIONS	HAND SURGERY
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) Fee: \$866.05 Benefit: 75% = \$649.55
46396	PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25 85% = \$253.05
46399	PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.) (Assist.) Fee: \$467.65 Benefit: 75% = \$350.75
46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.) (Assist.) Fee: \$467.65 Benefit: 75% = \$350.75
46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.) (Assist.) Fee: \$570.65 Benefit: 75% = \$428.00
46408	TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.) Fee: \$625.00 Benefit: 75% = \$468.75
46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.) Fee: \$366.80 Benefit: 75% = \$275.10
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.) (Assist.) Fee: \$475.35 Benefit: 75% = \$356.55 85% = \$410.15
46417	TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.) Fee: \$441.50 Benefit: 75% = \$331.15
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.) Fee: \$184.75 Benefit: 75% = \$138.60 85% = \$157.05
46423	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.) Fee: \$295.45 Benefit: 75% = \$221.60 85% = \$251.15
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) Fee: \$305.60 Benefit: 75% = \$229.20
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) Fee: \$373.55 Benefit: 75% = \$280.20 85% = \$317.55
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) Fee: \$407.60 Benefit: 75% = \$305.70
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) Fee: \$475.45 Benefit: 75% = \$356.60
46438	MALLET FINGER, closed pin fixation of (Anaes.) Fee: \$122.30 Benefit: 75% = \$91.75 85% = \$104.00
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.) Fee: \$295.45 Benefit: 75% = \$221.60 85% = \$251.15
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) Fee: \$253.60 Benefit: 75% = \$190.20
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.) Fee: \$441.50 Benefit: 75% = \$331.15
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.) Fee: \$550.20 Benefit: 75% = \$412.65
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) Fee: \$203.80 Benefit: 75% = \$152.85

OPERATIONS		ORTHOPAEDIC
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: \$237.80 Benefit: 75% = \$178.35 85% = \$202.15	
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: \$297.25 Benefit: 75% = \$222.95 85% = \$252.70	
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: \$273.55 Benefit: 75% = \$205.20 85% = \$232.55	
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: \$341.70 Benefit: 75% = \$256.30 85% = \$290.45	
46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.) Fee: \$998.45 Benefit: 75% = \$748.85 85% = \$933.25	
46507	DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.) Fee: \$1,161.50 Benefit: 75% = \$871.15	
46510	MACRODACTYLY, surgical reduction of enlarged elements - each digit (Anaes.) (Assist.) Fee: \$317.00 Benefit: 75% = \$237.75	
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies (Anaes.) Fee: \$51.05 Benefit: 75% = \$38.30 85% = \$43.40	
46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital (Anaes.) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70	
46519	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.) Fee: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45	
46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB, open operation and drainage for infection (Anaes.) (Assist.) Fee: \$380.40 Benefit: 75% = \$285.30	
46525	PULP SPACE INFECTION, PARONYCHIA OF HAND, incision for, when performed in an operating theatre of a hospital, not being a service to which another item in this Group applies (excluding after-care) (Anaes.) Fee: \$51.05 Benefit: 75% = \$38.30 85% = \$43.40	
46528	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, unguis fold and portion of the nail bed (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) Fee: \$76.90 Benefit: 75% = \$57.70 85% = \$65.40	
46534	NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
SUBGROUP 15 - ORTHOPAEDIC		
TREATMENT OF DISLOCATIONS		
<i>(Note: See paragraph T8.92 of explanatory notes to this Category)</i>		
47000	MANDIBLE, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$63.85 Benefit: 75% = \$47.90 85% = \$54.30	
47003	CLAVICLE, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$76.55 Benefit: 75% = \$57.45 85% = \$65.10	
47006	CLAVICLE, treatment of dislocation of, by open reduction (Anaes.) Fee: \$153.75 Benefit: 75% = \$115.35 85% = \$130.70	

OPERATIONS		ORTHOPAEDIC
47072	TOE, treatment of dislocation of, by open reduction (Anaes.) Fee: \$84.90 Benefit: 75% = \$63.70 85% = \$72.20	
TREATMENT OF FRACTURES		
<i>(Note: See paragraph T8.112 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: \$76.55 Benefit: 75% = \$57.45 85% = \$65.10	
47303	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$89.30 Benefit: 75% = \$67.00 85% = \$75.95	
47306	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by open reduction (Anaes.) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70	
47309	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by open reduction (Anaes.) Fee: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45	
47312	MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction (Anaes.) Fee: \$114.70 Benefit: 75% = \$86.05 85% = \$97.50	
47315	MIDDLE PHALANX of FINGER, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$131.80 Benefit: 75% = \$98.85 85% = \$112.05	
47318	MIDDLE PHALANX OF FINGER, treatment of fracture of, by open reduction (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
47321	MIDDLE PHALANX OF FINGER, treatment of intra-articular fracture of, by open reduction (Anaes.) Fee: \$191.25 Benefit: 75% = \$143.45	
47324	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
47327	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$178.45 Benefit: 75% = \$133.85 85% = \$151.70	
47330	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by open reduction (Anaes.) Fee: \$204.10 Benefit: 75% = \$153.10 85% = \$173.50	
47333	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (Anaes.) (Assist.) Fee: \$255.00 Benefit: 75% = \$191.25	
47336	METACARPAL, treatment of fracture of, by closed reduction (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
47339	METACARPAL, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$178.45 Benefit: 75% = \$133.85 85% = \$151.70	
47342	METACARPAL, treatment of fracture of, by open reduction (Anaes.) Fee: \$204.10 Benefit: 75% = \$153.10 85% = \$173.50	
47345	METACARPAL, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) Fee: \$255.00 Benefit: 75% = \$191.25	
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.) Fee: \$84.90 Benefit: 75% = \$63.70 85% = \$72.20	
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10 85% = \$289.10	

OPERATIONS		ORTHOPAEDIC
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: \$119.05 Benefit: 75% = \$89.30 85% = \$101.20	
47363	RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction (Anaes.) Fee: \$178.45 Benefit: 75% = \$133.85 85% = \$151.70	
47366	RADIUS OR ULNA, distal end of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$238.05 Benefit: 75% = \$178.55 85% = \$202.35	
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: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
47372	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) Fee: \$255.00 Benefit: 75% = \$191.25 85% = \$216.75	
47375	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10	
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: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
47381	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) Fee: \$229.55 Benefit: 75% = \$172.20 85% = \$195.15	
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$306.05 Benefit: 75% = \$229.55	
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 (Anaes.) (Assist.) Fee: \$263.50 Benefit: 75% = \$197.65 85% = \$224.00	
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: \$425.05 Benefit: 75% = \$318.80	
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: \$246.50 Benefit: 75% = \$184.90 85% = \$209.55	
47390	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) Fee: \$369.85 Benefit: 75% = \$277.40	
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$493.05 Benefit: 75% = \$369.80	
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes.) Fee: \$170.00 Benefit: 75% = \$127.50 85% = \$144.50	
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10	
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) Fee: \$255.00 Benefit: 75% = \$191.25 85% = \$216.75	
47405	RADIUS, treatment of fracture of head or neck of, closed reduction of (Anaes.) Fee: \$170.00 Benefit: 75% = \$127.50 85% = \$144.50	
47408	RADIUS, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10	

OPERATIONS		ORTHOPAEDIC
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70	
47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.) Fee: \$204.10 Benefit: 75% = \$153.10 85% = \$173.50	
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) Fee: \$238.05 Benefit: 75% = \$178.55 85% = \$202.35	
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) Fee: \$467.65 Benefit: 75% = \$350.75	
47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.) Fee: \$195.50 Benefit: 75% = \$146.65 85% = \$166.20	
47426	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) Fee: \$293.30 Benefit: 75% = \$220.00 85% = \$249.35	
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$391.00 Benefit: 75% = \$293.25	
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) Fee: \$488.85 Benefit: 75% = \$366.65	
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) Fee: \$374.15 Benefit: 75% = \$280.65 85% = \$318.05	
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) Fee: \$595.25 Benefit: 75% = \$446.45	
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) Fee: \$743.95 Benefit: 75% = \$558.00	
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.) Fee: \$204.10 Benefit: 75% = \$153.10 85% = \$173.50	
47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) Fee: \$306.05 Benefit: 75% = \$229.55	
47450	HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) Fee: \$408.10 Benefit: 75% = \$306.10	
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.) Fee: \$492.00 Benefit: 75% = \$369.00	
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.) Fee: \$238.05 Benefit: 75% = \$178.55 85% = \$202.35	
47456	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) Fee: \$357.20 Benefit: 75% = \$267.90 85% = \$303.65	
47459	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) Fee: \$476.15 Benefit: 75% = \$357.15	
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70	
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes.) Fee: \$204.10 Benefit: 75% = \$153.10 85% = \$173.50	
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70	

OPERATIONS		ORTHOPAEDIC
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.) Fee: \$144.55 Benefit: 75% = \$108.45 85% = \$122.90	
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25	
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.) Fee: \$382.70 Benefit: 75% = \$287.05	
47588	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) Fee: \$1,190.15 Benefit: 75% = \$892.65	
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: \$1,445.50 Benefit: 75% = \$1,084.15	
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.) Fee: \$195.50 Benefit: 75% = \$146.65 85% = \$166.20	
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes.) Fee: \$293.30 Benefit: 75% = \$220.00 85% = \$249.35	
47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) Fee: \$391.00 Benefit: 75% = \$293.25	
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) Fee: \$510.10 Benefit: 75% = \$382.60	
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: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$318.80 Benefit: 75% = \$239.10 85% = \$271.00	
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$369.85 Benefit: 75% = \$277.40 85% = \$314.40	
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$425.05 Benefit: 75% = \$318.80 85% = \$361.30	
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$531.50 Benefit: 75% = \$398.65	
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$369.85 Benefit: 75% = \$277.40 85% = \$314.40	
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$510.10 Benefit: 75% = \$382.60	
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes.) Fee: \$144.55 Benefit: 75% = \$108.45 85% = \$122.90	
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$306.05 Benefit: 75% = \$229.55 85% = \$260.15	
47633	METATARSAL, 1 of, treatment of fracture of (Anaes.) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70	
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	

OPERATIONS		ORTHOPAEDIC
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes.) Fee: \$204.10 Benefit: 75% = \$153.10 85% = \$173.50	
47642	METATARSALS, 2 of, treatment of fracture of (Anaes.) Fee: \$136.15 Benefit: 75% = \$102.15 85% = \$115.75	
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes.) Fee: \$204.10 Benefit: 75% = \$153.10 85% = \$173.50	
47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$271.90 Benefit: 75% = \$203.95	
47651	METATARSALS, 3 or more of, treatment of fracture of (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.) Fee: \$318.80 Benefit: 75% = \$239.10 85% = \$271.00	
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$425.05 Benefit: 75% = \$318.80	
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes.) Fee: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45	
47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70	
47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
47681	SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00	
47684	SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, with immobilisation by calipers or halo (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20 85% = \$615.05	
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: \$1,190.15 Benefit: 75% = \$892.65	
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: \$935.20 Benefit: 75% = \$701.40	
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: \$1,190.15 Benefit: 75% = \$892.65	
47696	SPINE, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10 85% = \$289.10	
47699	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (Anaes.) (Assist.) Fee: \$1,360.40 Benefit: 75% = \$1,020.30	
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: \$1,700.45 Benefit: 75% = \$1,275.35	
47703	SKULL, treatment of fracture of, each attendance Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00	

OPERATIONS		ORTHOPAEDIC
47705	SKULL CALIPERS, insertion of, as an independent procedure (Anaes.) (Assist.) Fee: \$255.00 Benefit: 75% = \$191.25	
47708	PLASTER JACKET, application of, as an independent procedure (Anaes.) Fee: \$195.50 Benefit: 75% = \$146.65 85% = \$166.20	
47711	HALO, application of, as an independent procedure (Anaes.) (Assist.) Fee: \$289.15 Benefit: 75% = \$216.90	
47714	HALO, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) Fee: \$216.75 Benefit: 75% = \$162.60	
47717	HALO-THORACIC TRACTION - application of both halo and thoracic jacket (Anaes.) (Assist.) Fee: \$382.70 Benefit: 75% = \$287.05	
47720	HALO-FEMORAL TRACTION, as an independent procedure (Anaes.) (Assist.) Fee: \$382.70 Benefit: 75% = \$287.05 85% = \$325.30	
47723	HALO-FEMORAL TRACTION, in conjunction with a major spine operation (Anaes.) (Assist.) Fee: \$382.70 Benefit: 75% = \$287.05 85% = \$325.30	
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.) Fee: \$127.55 Benefit: 75% = \$95.70	
47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50	
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10	
+ 47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance Fee: \$38.85 Benefit: 75% = \$29.15 85% = \$33.05	
47738	NASAL BONES, treatment of fracture of, by reduction (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.) Fee: \$433.80 Benefit: 75% = \$325.35	
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) Fee: \$367.25 Benefit: 75% = \$275.45	
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) Fee: \$367.25 Benefit: 75% = \$275.45	
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) Fee: \$215.70 Benefit: 75% = \$161.80 85% = \$183.35	
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) Fee: \$354.10 Benefit: 75% = \$265.60	
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) Fee: \$433.80 Benefit: 75% = \$325.35	
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) Fee: \$498.35 Benefit: 75% = \$373.80	
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.) Fee: \$393.45 Benefit: 75% = \$295.10	
47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) Fee: \$393.45 Benefit: 75% = \$295.10	

OPERATIONS		ORTHOPAEDIC
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) Fee: \$511.45 Benefit: 75% = \$383.60	
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) Fee: \$511.45 Benefit: 75% = \$383.60 85% = \$446.25	
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) Fee: \$649.05 Benefit: 75% = \$486.80	
47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) Fee: \$649.05 Benefit: 75% = \$486.80	
GENERAL		
47900	BONE CYST, injection into or aspiration of (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
47903	EPICONDYLITIS, open operation for (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.) Fee: \$51.05 Benefit: 75% = \$38.30 85% = \$43.40	
47906	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital (Anaes.) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70	
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: \$51.05 Benefit: 75% = \$38.30 85% = \$43.40	
47915	INGROWING NAIL OF TOE, wedge resection for, including removal of segment of nail, unguis fold and portion of the nail bed (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
47916	INGROWING NAIL OF TOE, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) Fee: \$76.90 Benefit: 75% = \$57.70 85% = \$65.40	
47918	INGROWING TOENAIL, radical excision of nailbed (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
47920	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) Fee: \$343.85 Benefit: 75% = \$257.90	
47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.) Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70	
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: \$34.00 Benefit: 75% = \$25.50 85% = \$28.90	
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 - per bone (Anaes.) Fee: \$127.55 Benefit: 75% = \$95.70	
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, <u>removal of</u> , not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.) Fee: \$238.05 Benefit: 75% = \$178.55	
47933	EXOSTOSIS OF SMALL BONE, excision of, including simple removal of bunion and any associated bursa (Anaes.) Fee: \$186.95 Benefit: 75% = \$140.25 85% = \$158.95	
47936	EXOSTOSIS OF LARGE BONE, excision of (Anaes.) (Assist.) Fee: \$229.55 Benefit: 75% = \$172.20	
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) Fee: \$144.55 Benefit: 75% = \$108.45	

OPERATIONS		ORTHOPAEDIC
47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) Fee: \$170.00 Benefit: 75% = \$127.50 85% = \$144.50	
47954	TENDON, repair of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10 85% = \$289.10	
47957	TENDON, large, lengthening of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$255.00 Benefit: 75% = \$191.25	
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) Fee: \$119.05 Benefit: 75% = \$89.30 85% = \$101.20	
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.) Fee: \$195.50 Benefit: 75% = \$146.65 85% = \$166.20	
47966	TENDON OR LIGAMENT, TRANSFER, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$391.00 Benefit: 75% = \$293.25	
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$238.05 Benefit: 75% = \$178.55	
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.) Fee: \$190.20 Benefit: 75% = \$142.65	
47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.) Fee: \$333.35 Benefit: 75% = \$250.05	
47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) Fee: \$202.50 Benefit: 75% = \$151.90	
47981	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes.) Fee: \$135.95 Benefit: 75% = \$102.00 85% = \$115.60	
47982	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.) Fee: \$329.55 Benefit: 75% = \$247.20	
BONE GRAFTS		
48200	FEMUR, bone graft to (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
48203	FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.) Fee: \$824.75 Benefit: 75% = \$618.60	
48206	TIBIA, bone graft to (Anaes.) (Assist.) Fee: \$510.65 Benefit: 75% = \$383.00	
48209	TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.) Fee: \$654.70 Benefit: 75% = \$491.05	
48212	HUMERUS, bone graft to (Anaes.) (Assist.) Fee: \$510.65 Benefit: 75% = \$383.00	
48215	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.) Fee: \$654.70 Benefit: 75% = \$491.05	
48218	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.) Fee: \$510.65 Benefit: 75% = \$383.00	
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
48224	RADIUS OR ULNA, bone graft to (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10	

OPERATIONS		ORTHOPAEDIC
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) Fee: \$442.10 Benefit: 75% = \$331.60	
48230	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.) Fee: \$382.70 Benefit: 75% = \$287.05	
48233	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.) Fee: \$552.65 Benefit: 75% = \$414.50	
48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.) Fee: \$722.70 Benefit: 75% = \$542.05	
48239	BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$399.55 Benefit: 75% = \$299.70	
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$552.65 Benefit: 75% = \$414.50	
OSTEOTOMY AND OSTEECTOMY		
48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25	
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$467.65 Benefit: 75% = \$350.75	
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25	
48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$467.65 Benefit: 75% = \$350.75	
48412	HUMERUS, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$569.50 Benefit: 75% = \$427.15	
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$722.70 Benefit: 75% = \$542.05	
48418	TIBIA, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$569.50 Benefit: 75% = \$427.15 85% = \$504.30	
48421	TIBIA, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$722.70 Benefit: 75% = \$542.05	
48424	FEMUR OR PELVIS, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
48427	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$824.75 Benefit: 75% = \$618.60	
EPIPHYSEODESIS		
48500	FEMUR, epiphysiodesis of (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25	
48503	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25	
48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) Fee: \$442.10 Benefit: 75% = \$331.60	
48509	EPIPHYSEODESIS, staple arrest of hemiepiphysis (Anaes.) Fee: \$212.65 Benefit: 75% = \$159.50	

OPERATIONS		ORTHOPAEDIC
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.) Fee: \$807.70 Benefit: 75% = \$605.80	
SPINE		
48600	SPINE, MANIPULATION OF, performed in the operating theatre of a hospital (Anaes.) Fee: \$84.90 Benefit: 75% = \$63.70	
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, not being a service associated with a service to which item 48600 or 50115 applies (Anaes.) Fee: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45	
48606	SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (Anaes.) (Assist.) Fee: \$1,190.15 Benefit: 75% = \$892.65	
48612	SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Anaes.) (Assist.) Fee: \$2,210.60 Benefit: 75% = \$1,657.95	
48613	SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) Fee: \$3,144.35 Benefit: 75% = \$2,358.30	
48615	SCOLIOSIS, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Anaes.) (Assist.) Fee: \$399.55 Benefit: 75% = \$299.70	
48618	SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Anaes.) (Assist.) Fee: \$2,210.60 Benefit: 75% = \$1,657.95	
48621	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Anaes.) (Assist.) Fee: \$1,445.50 Benefit: 75% = \$1,084.15	
48624	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) Fee: \$1,785.60 Benefit: 75% = \$1,339.20	
48627	SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Anaes.) (Assist.) Fee: \$2,295.50 Benefit: 75% = \$1,721.65	
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: \$2,550.65 Benefit: 75% = \$1,913.00	
48632	SCOLIOSIS, congenital, vertebral resection and fusion for (Anaes.) (Assist.) Fee: \$1,409.95 Benefit: 75% = \$1,057.50	
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 T8.117 of explanatory notes to this Category)</i> Fee: \$731.10 Benefit: 75% = \$548.35 85% = \$665.90	
48639	VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixation (Anaes.) (Assist.) Fee: \$1,232.75 Benefit: 75% = \$924.60	
48640	VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) Fee: \$3,144.35 Benefit: 75% = \$2,358.30	
48642	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Anaes.) (Assist.) Fee: \$722.70 Benefit: 75% = \$542.05	
48645	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Anaes.) (Assist.) Fee: \$977.75 Benefit: 75% = \$733.35	

OPERATIONS	ORTHOPAEDIC
48648	SPINE, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Anaes.) (Assist.) Fee: \$977.75 Benefit: 75% = \$733.35
48651	SPINE, bone graft to, (postero-lateral fusion) - more than 2 levels (Anaes.) (Assist.) Fee: \$1,360.40 Benefit: 75% = \$1,020.30
48654	SPINAL FUSION (posterior interbody), with partial or total laminectomy, 1 level (Anaes.) (Assist.) Fee: \$977.75 Benefit: 75% = \$733.35
48657	SPINAL FUSION (posterior interbody), with partial or total laminectomy, more than 1 level (Anaes.) (Assist.) Fee: \$1,360.40 Benefit: 75% = \$1,020.30
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 T8.118 of explanatory notes to this Category)</i> Fee: \$977.75 Benefit: 75% = \$733.35
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 T8.118 of explanatory notes to this Category)</i> Fee: \$731.10 Benefit: 75% = \$548.35
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 T8.118 of explanatory notes to this Category)</i> Fee: \$442.10 Benefit: 75% = \$331.60
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.) <i>(See para T8.118 of explanatory notes to this Category)</i> Fee: \$1,317.80 Benefit: 75% = \$988.35
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.) <i>(See para T8.118 of explanatory notes to this Category)</i> Fee: \$986.40 Benefit: 75% = \$739.80
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.) <i>(See para T8.118 of explanatory notes to this Category)</i> Fee: \$595.25 Benefit: 75% = \$446.45
48678	SPINE, simple internal fixation of, involving 1 or more of facet screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (Anaes.) (Assist.) <i>(See para T8.119 of explanatory notes to this Category)</i> Fee: \$510.65 Benefit: 75% = \$383.00
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.) <i>(See para T8.119 of explanatory notes to this Category)</i> Fee: \$850.25 Benefit: 75% = \$637.70
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.) <i>(See para T8.119 of explanatory notes to this Category)</i> Fee: \$850.25 Benefit: 75% = \$637.70
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.) <i>(See para T8.119 of explanatory notes to this Category)</i> Fee: \$1,190.15 Benefit: 75% = \$892.65
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.) <i>(See para T8.119 of explanatory notes to this Category)</i> Fee: \$1,360.40 Benefit: 75% = \$1,020.30

OPERATIONS		ORTHOPAEDIC
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 T8.120 of explanatory notes to this Category) Fee: \$1,619.85 Benefit: 75% = \$1,214.90 85% = \$1,554.65	
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 T8.120 of explanatory notes to this Category) Fee: \$1,091.80 Benefit: 75% = \$818.85 85% = \$1,026.60	
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 T8.120 of explanatory notes to this Category) Fee: \$528.05 Benefit: 75% = \$396.05 85% = \$462.85	
SHOULDER		
48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.) Fee: \$255.00 Benefit: 75% = \$191.25 85% = \$216.75	
48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.) Fee: \$510.10 Benefit: 75% = \$382.60	
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: \$510.10 Benefit: 75% = \$382.60	
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: \$680.25 Benefit: 75% = \$510.20	
48912	SHOULDER, arthrotomy of (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25 85% = \$253.05	
48915	SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.) Fee: \$1,360.40 Benefit: 75% = \$1,020.30	
48921	SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.) Fee: \$1,402.85 Benefit: 75% = \$1,052.15	
48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.) Fee: \$1,615.50 Benefit: 75% = \$1,211.65	
48927	SHOULDER prosthesis, removal of (Anaes.) (Assist.) Fee: \$331.50 Benefit: 75% = \$248.65	
48930	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
48933	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.) Fee: \$892.75 Benefit: 75% = \$669.60	
48936	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
48939	SHOULDER, arthrodesis of (Anaes.) (Assist.) Fee: \$977.75 Benefit: 75% = \$733.35	

OPERATIONS		ORTHOPAEDIC
48942	SHOULDER, arthrodesis of, including removal of prosthesis, requiring bone grafting or internal fixation (Anaes.) (Assist.) Fee: \$1,275.35 Benefit: 75% = \$956.55	
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) Fee: \$246.50 Benefit: 75% = \$184.90	
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: \$552.65 Benefit: 75% = \$414.50	
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: \$807.70 Benefit: 75% = \$605.80	
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: \$850.25 Benefit: 75% = \$637.70	
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: \$977.75 Benefit: 75% = \$733.35	
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: \$850.25 Benefit: 75% = \$637.70	
ELBOW		
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25	
49103	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.) Fee: \$637.65 Benefit: 75% = \$478.25	
49106	ELBOW, arthrodesis of (Anaes.) (Assist.) Fee: \$850.25 Benefit: 75% = \$637.70 85% = \$785.05	
49109	ELBOW, total synovectomy of (Anaes.) (Assist.) Fee: \$637.65 Benefit: 75% = \$478.25	
49112	ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.) Fee: \$637.65 Benefit: 75% = \$478.25	
49115	ELBOW, total joint replacement of (Anaes.) (Assist.) Fee: \$1,020.20 Benefit: 75% = \$765.15	
49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,346.65 Benefit: 75% = \$1,010.00	
49117	ELBOW, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,615.95 Benefit: 75% = \$1,212.00	
49118	ELBOW, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) Fee: \$246.50 Benefit: 75% = \$184.90	
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: \$552.65 Benefit: 75% = \$414.50	

OPERATIONS		ORTHOPAEDIC
WRIST		
49200	WRIST, arthrodesis of, including bone graft, with or without internal fixation of the radiocarpal joint (Anaes.) (Assist.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$739.60 Benefit: 75% = \$554.70	
49203	WRIST, limited arthrodesis of the intercarpal joint, including bone graft (Anaes.) (Assist.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$552.65 Benefit: 75% = \$414.50	
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$510.10 Benefit: 75% = \$382.60	
49209	WRIST, total replacement arthroplasty of (Anaes.) (Assist.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$680.25 Benefit: 75% = \$510.20	
49210	WRIST, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) Fee: \$897.90 Benefit: 75% = \$673.45	
49211	WRIST, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,077.50 Benefit: 75% = \$808.15	
49212	WRIST, arthrotomy of (Anaes.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$212.65 Benefit: 75% = \$159.50	
49215	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.) (Assist.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$586.75 Benefit: 75% = \$440.10	
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.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$246.50 Benefit: 75% = \$184.90	
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.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$552.65 Benefit: 75% = \$414.50	
49224	WRIST, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy (Anaes.) (Assist.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$637.65 Benefit: 75% = \$478.25	
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.) <i>(See para T8.121 of explanatory notes to this Category)</i> Fee: \$637.65 Benefit: 75% = \$478.25	
HIP		
49300	SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.) Fee: \$470.70 Benefit: 75% = \$353.05	
49303	HIP, arthrotomy of, including lavage, drainage or biopsy when performed (Anaes.) (Assist.) Fee: \$493.05 Benefit: 75% = \$369.80	
49306	HIP arthrodesis of (Anaes.) (Assist.) Fee: \$977.75 Benefit: 75% = \$733.35	

OPERATIONS		ORTHOPAEDIC
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: \$1,190.15 Benefit: 75% = \$892.65	
49545	KNEE, revision arthrodesis of (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
49548	KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.) Fee: \$850.25 Benefit: 75% = \$637.70	
49551	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.) Fee: \$1,190.15 Benefit: 75% = \$892.65	
49554	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.) Fee: \$1,700.45 Benefit: 75% = \$1,275.35	
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: \$246.50 Benefit: 75% = \$184.90	
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: \$246.50 Benefit: 75% = \$184.90	
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: \$369.10 Benefit: 75% = \$276.85	
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: \$498.15 Benefit: 75% = \$373.65	
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: \$608.75 Benefit: 75% = \$456.60	
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: \$664.20 Benefit: 75% = \$498.15	
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: \$719.45 Benefit: 75% = \$539.60	
49564	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer (Anaes.) (Assist.) Fee: \$829.90 Benefit: 75% = \$622.45	
49566	KNEE, arthroscopic total synovectomy of (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
ANKLE		
49700	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) Fee: \$246.50 Benefit: 75% = \$184.90	
49703	ANKLE, arthroscopic surgery of (Anaes.) (Assist.) Fee: \$552.65 Benefit: 75% = \$414.50	
49706	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25	

OPERATIONS		ORTHOPAEDIC
49709	ANKLE, ligamentous stabilisation of (Anaes.) (Assist.) Fee: \$637.65 Benefit: 75% = \$478.25	
49712	ANKLE, arthrodesis of (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
49715	ANKLE, total joint replacement of (Anaes.) (Assist.) Fee: \$1,020.20 Benefit: 75% = \$765.15	
49716	ANKLE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,346.65 Benefit: 75% = \$1,010.00	
49717	ANKLE, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,615.95 Benefit: 75% = \$1,212.00	
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10	
49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment Fee: \$212.65 Benefit: 75% = \$159.50 85% = \$180.80	
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.) Fee: \$595.25 Benefit: 75% = \$446.45	
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.) Fee: \$255.00 Benefit: 75% = \$191.25	
49728	ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.) Fee: \$509.95 Benefit: 75% = \$382.50	
FOOT		
49800	FOOT, flexor or extensor tendon, primary repair of (Anaes.) Fee: \$119.05 Benefit: 75% = \$89.30 85% = \$101.20	
49803	FOOT, flexor or extensor tendon, secondary repair of (Anaes.) Fee: \$153.10 Benefit: 75% = \$114.85 85% = \$130.15	
49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes.) Fee: \$119.05 Benefit: 75% = \$89.30 85% = \$101.20	
49809	FOOT, open tenotomy of, with or without tenoplasty (Anaes.) Fee: \$195.50 Benefit: 75% = \$146.65	
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$391.00 Benefit: 75% = \$293.25	
49815	FOOT, triple arthrodesis of (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20	
49818	FOOT, excision of calcaneal spur (Anaes.) (Assist.) Fee: \$246.50 Benefit: 75% = \$184.90	
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.) (Assist.) Fee: \$391.00 Benefit: 75% = \$293.25	
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.) (Assist.) Fee: \$684.45 Benefit: 75% = \$513.35	
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.) Fee: \$425.05 Benefit: 75% = \$318.80	

OPERATIONS		ORTHOPAEDIC
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.) Fee: \$743.95 Benefit: 75% = \$558.00	
49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - unilateral (Anaes.) (Assist.) Fee: \$467.65 Benefit: 75% = \$350.75	
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - bilateral (Anaes.) (Assist.) Fee: \$807.70 Benefit: 75% = \$605.80	
49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallucis tendon, including internal fixation where performed - unilateral (Anaes.) (Assist.) Fee: \$584.55 Benefit: 75% = \$438.45	
49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallucis tendon, including internal fixation where performed - bilateral (Anaes.) (Assist.) Fee: \$1,009.45 Benefit: 75% = \$757.10	
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.) (Assist.) Fee: \$467.65 Benefit: 75% = \$350.75	
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.) (Assist.) Fee: \$807.70 Benefit: 75% = \$605.80	
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint (Anaes.) (Assist.) Fee: \$425.05 Benefit: 75% = \$318.80	
49848	FOOT, correction of claw or hammer toe (Anaes.) Fee: \$144.55 Benefit: 75% = \$108.45 85% = \$122.90	
49851	FOOT, correction of claw or hammer toe with internal fixation (Anaes.) Fee: \$186.95 Benefit: 75% = \$140.25	
49854	FOOT, radical plantar fasciotomy or fasciectomy of (Anaes.) (Assist.) Fee: \$340.10 Benefit: 75% = \$255.10	
49857	FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.) Fee: \$314.55 Benefit: 75% = \$235.95	
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.) Fee: \$255.00 Benefit: 75% = \$191.25	
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.) Fee: \$382.70 Benefit: 75% = \$287.05	
49866	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.) Fee: \$271.90 Benefit: 75% = \$203.95	
49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (Anaes.) Fee: \$51.05 Benefit: 75% = \$38.30 85% = \$43.40	
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: \$246.50 Benefit: 75% = \$184.90 85% = \$209.55	
50102	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$552.65 Benefit: 75% = \$414.50	
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$297.65 Benefit: 75% = \$223.25	
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$282.05 Benefit: 75% = \$211.55 85% = \$239.75	

OPERATIONS	ORTHOPAEDIC
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: \$425.05 Benefit: 75% = \$318.80
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$425.05 Benefit: 75% = \$318.80
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: \$326.05 Benefit: 75% = \$244.55
+ 50115	JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$129.10 Benefit: 75% = \$96.85 85% = \$109.75
50118	SUBTALAR JOINT, arthrodesis of (Anaes.) (Assist.) Fee: \$391.00 Benefit: 75% = \$293.25
50121	GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.) Fee: \$765.25 Benefit: 75% = \$573.95
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 T8.122 of explanatory notes to this Category)</i> Fee: \$26.75 Benefit: 75% = \$20.10 85% = \$22.75
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 T8.122 of explanatory notes to this Category)</i> Fee: \$26.75 Benefit: 75% = \$20.10 85% = \$22.75
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.) Fee: \$634.40 Benefit: 75% = \$475.80
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) Fee: \$282.05 Benefit: 75% = \$211.55
MALIGNANT DISEASE	
50200	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) Fee: \$170.00 Benefit: 75% = \$127.50 85% = \$144.50
50201	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.) Fee: \$297.55 Benefit: 75% = \$223.20
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) Fee: \$374.15 Benefit: 75% = \$280.65 85% = \$318.05
50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) Fee: \$552.65 Benefit: 75% = \$414.50
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: \$680.25 Benefit: 75% = \$510.20
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: \$1,487.90 Benefit: 75% = \$1,115.95
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: \$1,870.50 Benefit: 75% = \$1,402.90

OPERATIONS		ORTHOPAEDIC
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint (Anaes.) (Assist.) Fee: \$2,465.70 Benefit: 75% = \$1,849.30	
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.) Fee: \$2,295.50 Benefit: 75% = \$1,721.65	
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: \$2,550.65 Benefit: 75% = \$1,913.00 85% = \$2,485.45	
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.) Fee: \$2,975.75 Benefit: 75% = \$2,231.85	
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.) Fee: \$1,530.35 Benefit: 75% = \$1,147.80	
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.) Fee: \$1,955.50 Benefit: 75% = \$1,466.65	
50236	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.) Fee: \$1,530.35 Benefit: 75% = \$1,147.80	
50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$1,020.20 Benefit: 75% = \$765.15	
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: \$1,045.45 Benefit: 75% = \$784.10	
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 - payable only once per limb in any 12 month period (Anaes.) (Assist.) Fee: \$1,427.40 Benefit: 75% = \$1,070.55	
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: \$2,228.70 Benefit: 75% = \$1,671.55 85% = \$2,163.50	
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, not being a service to which item 50303 or 50306 applies (Anaes.) (Assist.) Fee: \$275.45 Benefit: 75% = \$206.60	
50312	ANKLE, synovectomy of (Anaes.) (Assist.) Fee: \$632.25 Benefit: 75% = \$474.20	
50315	TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.) Fee: \$626.05 Benefit: 75% = \$469.55	
50318	TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.) Fee: \$626.05 Benefit: 75% = \$469.55	
50321	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.) Fee: \$838.85 Benefit: 75% = \$629.15	
50324	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.) Fee: \$1,195.75 Benefit: 75% = \$896.85	
50327	TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.) Fee: \$1,458.60 Benefit: 75% = \$1,093.95	

OPERATIONS		ORTHOPAEDIC
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: \$788.80 Benefit: 75% = \$591.60	
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: \$588.40 Benefit: 75% = \$441.30	
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: \$1,032.95 Benefit: 75% = \$774.75	
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: \$588.40 Benefit: 75% = \$441.30	
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 (Anaes.) Fee: \$206.55 Benefit: 75% = \$154.95 85% = \$175.60	
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.) Fee: \$763.70 Benefit: 75% = \$572.80	
50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.) Fee: \$2,508.10 Benefit: 75% = \$1,881.10	
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: \$419.55 Benefit: 75% = \$314.70	
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.) Fee: \$832.65 Benefit: 75% = \$624.50	
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.) Fee: \$381.90 Benefit: 75% = \$286.45	
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.) Fee: \$519.60 Benefit: 75% = \$389.70	
50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.) Fee: \$901.50 Benefit: 75% = \$676.15	
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: \$1,183.15 Benefit: 75% = \$887.40 85% = \$1,117.95	
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: \$1,596.35 Benefit: 75% = \$1,197.30 85% = \$1,531.15	
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: \$1,183.15 Benefit: 75% = \$887.40 85% = \$1,117.95	
50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.) Fee: \$976.55 Benefit: 75% = \$732.45	
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) Fee: \$901.50 Benefit: 75% = \$676.15 85% = \$836.30	

OPERATIONS	ORTHOPAEDIC
50426	<p style="text-align: center;">TUMOROUS CONDITIONS</p> <p>DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.) Fee: \$419.55 Benefit: 75% = \$314.70</p>
	<p style="text-align: center;">SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY</p>
50450	<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. 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.) <i>(See para T8.123 of explanatory notes to this Category)</i> Fee: \$1,108.00 Benefit: 75% = \$831.00</p>
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. (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, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) <i>(See para T8.123 of explanatory notes to this Category)</i> Fee: \$1,108.00 Benefit: 75% = \$831.00</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. b) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) <i>(See para T8.123 of explanatory notes to this Category)</i> Fee: \$1,254.75 Benefit: 75% = \$941.10</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. (b) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) <i>(See para T8.123 of explanatory notes to this Category)</i> Fee: \$1,254.75 Benefit: 75% = \$941.10</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. b) Correction of muscle imbalance by tendon transfer/transfers. c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) <i>(See para T8.123 of explanatory notes to this Category)</i> Fee: \$1,873.35 Benefit: 75% = \$1,405.05</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. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) <i>(See para T8.123 of explanatory notes to this Category)</i> Fee: \$1,873.35 Benefit: 75% = \$1,405.05</p>

OPERATIONS	ORTHOPAEDIC
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.) <i>(See para T8.123 of explanatory notes to this Category)</i></p> <p>Fee: \$2,638.60 Benefit: 75% = \$1,978.95</p>
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.) <i>(See para T8.123 of explanatory notes to this Category)</i></p> <p>Fee: \$2,638.60 Benefit: 75% = \$1,978.95</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.) <i>(See para T8.123 of explanatory notes to this Category)</i></p> <p>Fee: \$3,346.40 Benefit: 75% = \$2,509.80</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.) <i>(See para T8.123 of explanatory notes to this Category)</i></p> <p>Fee: \$3,346.40 Benefit: 75% = \$2,509.80</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.) <i>(See para T8.123 of explanatory notes to this Category)</i></p> <p>Fee: \$3,861.40 Benefit: 75% = \$2,896.05</p>

OPERATIONS	ORTHOPAEDIC
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.) <i>(See para T8.123 of explanatory notes to this Category)</i></p> <p>Fee: \$3,861.40 Benefit: 75% = \$2,896.05</p>
TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS	
50500	<p>RADIUS OR ULNA, distal end of, <i>with open growth plate</i>, treatment of fracture of, by closed reduction (Anaes.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$249.85 Benefit: 75% = \$187.40 85% = \$212.40</p>
50504	<p>RADIUS OR ULNA, distal end of, <i>with open growth plate</i>, treatment of fracture of, by open reduction (Anaes.) (Assist.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$333.25 Benefit: 75% = \$249.95 85% = \$283.30</p>
50508	<p>RADIUS, distal end of, <i>with open growth plate</i>, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$357.00 Benefit: 75% = \$267.75 85% = \$303.45</p>
50512	<p>RADIUS, distal end of, <i>with open growth plate</i>, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$476.20 Benefit: 75% = \$357.15</p>
50516	<p>RADIUS OR ULNA, shaft of, <i>with open growth plate</i>, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$321.35 Benefit: 75% = \$241.05 85% = \$273.15</p>
50520	<p>RADIUS OR ULNA, shaft of, <i>with open growth plate</i>, treatment of fracture of, by open reduction (Anaes.) (Assist.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$428.40 Benefit: 75% = \$321.30</p>
50524	<p>RADIUS OR ULNA, shaft of, <i>with open growth plate</i>, 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 (Anaes.) (Assist.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$368.90 Benefit: 75% = \$276.70 85% = \$313.60</p>
50528	<p>RADIUS OR ULNA, shaft of, <i>with open growth plate</i>, 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.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$595.10 Benefit: 75% = \$446.35</p>
50532	<p>RADIUS AND ULNA, shafts of, <i>with open growth plates</i>, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$517.80 Benefit: 75% = \$388.35</p>
50536	<p>RADIUS AND ULNA, shafts of, <i>with open growth plates</i>, treatment of fracture of, by open reduction (Anaes.) (Assist.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$690.30 Benefit: 75% = \$517.75</p>
50540	<p>OLECRANON, <i>with open growth plate</i>, treatment of fracture of, by open reduction (Anaes.) (Assist.) <i>(See para T8.123 and T8.124 of explanatory notes to this Category)</i></p> <p>Fee: \$476.20 Benefit: 75% = \$357.15</p>

OPERATIONS		ORTHOPAEDIC
50544	RADIUS, <i>with open growth plate</i> , treatment of fracture of head or neck of, by closed reduction of (Anaes.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$238.05 Benefit: 75% = \$178.55 85% = \$202.35	
50548	RADIUS, <i>with open growth plate</i> , treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$476.20 Benefit: 75% = \$357.15	
50552	HUMERUS, proximal, <i>with open growth plate</i> , treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$410.65 Benefit: 75% = \$308.00 85% = \$349.10	
50556	HUMERUS, proximal, <i>with open growth plate</i> , treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$547.45 Benefit: 75% = \$410.60	
50560	HUMERUS, shaft of, <i>with open growth plate</i> , treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$428.40 Benefit: 75% = \$321.30	
50564	HUMERUS, shaft of, <i>with open growth plate</i> , treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$571.35 Benefit: 75% = \$428.55	
50568	HUMERUS, <i>with open growth plate</i> , supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$500.00 Benefit: 75% = \$375.00 85% = \$434.80	
50572	HUMERUS, <i>with open growth plate</i> , 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 (Anaes.) (Assist.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$666.55 Benefit: 75% = \$499.95	
50576	FEMUR, <i>with open growth plate</i> , treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$547.45 Benefit: 75% = \$410.60 85% = \$482.25	
50580	TIBIA, <i>with open growth plate</i> , 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 T8.123 and T8.124 of explanatory notes to this Category) Fee: \$571.35 Benefit: 75% = \$428.55	
50584	TIBIA, distal, <i>with open growth plate</i> , treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$547.45 Benefit: 75% = \$410.60	
50588	TIBIA AND FIBULA, <i>with open growth plates</i> , treatment of fracture of, by internal fixation (Anaes.) (Assist.) (See para T8.123 and T8.124 of explanatory notes to this Category) Fee: \$714.10 Benefit: 75% = \$535.60	
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 (Anaes.) (Assist.) (See para T8.123 of explanatory notes to this Category) Fee: \$392.55 Benefit: 75% = \$294.45 85% = \$333.70	
50604	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.) (See para T8.123 of explanatory notes to this Category) Fee: \$1,666.25 Benefit: 75% = \$1,249.70	

OPERATIONS		ORTHOPAEDIC
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 T8.123 of explanatory notes to this Category) Fee: \$3,094.80 Benefit: 75% = \$2,321.10	
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 T8.123 of explanatory notes to this Category) Fee: \$4,402.05 Benefit: 75% = \$3,301.55	
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 T8.123 of explanatory notes to this Category) Fee: \$559.35 Benefit: 75% = \$419.55	
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 T8.123 of explanatory notes to this Category) Fee: \$3,094.80 Benefit: 75% = \$2,321.10	
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 T8.123 of explanatory notes to this Category) Fee: \$3,094.80 Benefit: 75% = \$2,321.10	
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 T8.123 of explanatory notes to this Category) Fee: \$3,822.90 Benefit: 75% = \$2,867.20	
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 T8.123 of explanatory notes to this Category) Fee: \$3,213.75 Benefit: 75% = \$2,410.35	
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 T8.123 of explanatory notes to this Category) Fee: \$3,570.85 Benefit: 75% = \$2,678.15	
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 T8.123 of explanatory notes to this Category) Fee: \$1,973.95 Benefit: 75% = \$1,480.50	
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 T8.123 of explanatory notes to this Category) Fee: \$1,904.55 Benefit: 75% = \$1,428.45	
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 T8.123 of explanatory notes to this Category) Fee: \$374.55 Benefit: 75% = \$280.95 85% = \$318.40	
50654	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.) (See para T8.123 of explanatory notes to this Category) Fee: \$448.55 Benefit: 75% = \$336.45	
50658	HIP DYSPLASIA or DISLOCATION, in a child, examination and manipulation of the hip under anaesthesia (Anaes.) (See para T8.123 of explanatory notes to this Category) Fee: \$178.60 Benefit: 75% = \$133.95 85% = \$151.85	

OPERATIONS

RADIOFREQUENCY ABLATION

SUBGROUP 16 - RADIOFREQUENCY ABLATION

50950	<p>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.)</p> <p>Fee: \$737.95 Benefit: 75% = \$553.50 85% = \$672.75</p>
50952	<p>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:</p> <ul style="list-style-type: none"> - 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.) <p><i>(See para T8.125 of explanatory notes to this Category)</i></p> <p>Fee: \$737.95 Benefit: 75% = \$553.50 85% = \$672.75</p>

ASSISTANCE AT OPERATIONS	ASSISTANCE AT OPERATIONS
GROUP T9 - ASSISTANCE AT OPERATIONS	
51300	<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> <p>Fee: \$77.95 Benefit: 75% = \$58.50 85% = \$66.30</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</p> <p>Fee: \$112.60 Benefit: 75% = \$84.45 85% = \$95.75</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</p> <p>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</p> <p>Fee: \$245.95 Benefit: 75% = \$184.50 85% = \$209.10</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: \$162.35 Benefit: 75% = \$121.80 85% = \$138.00</p>

Service	Item	Service	Item
ileo-rectal, with total colectomy	32012	Anrostomy, radical	41710,41713
intrathoracic, congenital heart disease	38727,38730	Antrum, drainage of, through tooth socket	41719
microvascular, in plastic surgery	45502	intranasal, operation on	41716
oesophageal atresia, neonatal	43855	maxillary, lavage of	41704
saphenous vein, for femoral vein bypass	34809	maxillary, proof puncture, lavage	41698,41701
vena cava, for congenital heart disease	38721,38724	removal of foreign body from	41716
Aneurysm, cerebrovascular, clipping/reinforcement	39800	Anus, dilatation of (Lord's procedure)	32153
intracranial proximal artery clipping	39806	Aorta, anastomosis, congenital heart disease	38706,38709
intracranial, ligation cervical vessels	39812	thoracic, management of rupture/dissection	38572
left ventricular, plication of	38506	thoracic, repair/replacement procedures	38550-38571
left ventricular, resection	38507,38508	Aortic bypass	32708,32710,32711
major artery, replacement/repair	33050-33181	endarterectomy	33509
Angiofibroma, face/neck, removal by laser excision	30190	interruption, repair of	38712
nasopharyngeal, removal	41767	valve leaflet/s, decalcification of	38483
Angioma, cauterisation/injection into	45027	Aorto-duodenal fistula, repair of	34160,34163,34166
excision of	45030-45036	Aorto-femoral endarterectomy	33515
Angioplasty, peripheral laser	35315	Aorto-iliac endarterectomy	33512
transluminal balloon	35300-35303	Aortopexy for tracheomalacia	43909
Angioscopy	35324,35327	Appendiceal abscess, laparotomy for drainage	30394
Ankle, achilles tendon, operation for lengthening	49727	Appendicectomy	30571,30572,30574
achilles tendon, repair of	49718,49721,49724	Appendix, ruptured, laparotomy for drainage	30394
and foot, tibialis tendon transfer	50339,50342	Arachnoidal cyst, craniotomy for	39718
arthrodesis of	49712	Arch Bars, to maxilla or mandible, removal of	45823
arthroscopic surgery of	49703	Areola, reconstruction of	45545,45546
arthroscopy of, diagnostic	49700	Arm, amputation or disarticulation of	44328
arthrotomy of	49706	Arnold Chiari malformation, decompression of	40106
dislocation, treatment of	47063,47066	Arrhythmia ablation	38287,38290,38293
fracture, treatment of	47594-47603	surgery	38512-38524
gastrocnemius aponeurosis, operation for lengthening	49728	Arterial anastomosis, not otherwise covered	32766,32769
jerk test for half relaxation time	*	atherectomy, peripheral	35312
ligamentous stabilisation of	49709	cannulation for infusion chemotherapy, open	34524
major tendon repair	49718	catheterisation, peripheral	35317-35321
revision arthroplasty	49716,49717	line for blood pressure monitoring	13876
synovectomy of	50312	puncture and blood collection, diagnostic	13839
tibialis tendon transfer	50339,50342	Arteries, major, access as part of re-operation	35202
total joint replacement	49715	Arteriography, operative	35200
Annuloplasty, heart valve	38475,38477,38478	Arteriovenous access device, insertion of	34512
Anophthalmic orbit, insertion cartilage/implant	42518	access device, prosthetic, correction of	34518
orbit, placement of motility integrating peg	42518	access device, thrombectomy of	34515
orbit, removal of implant from socket	42518	anastomosis of upper or lower limb	34503,34509
socket, treatment as secondary procedure	42521	fistula extremity, surgically created, closure	34130
Anoplasty for anal stricture	32123	fistula, dissection and ligation/repair	34112-34127
Anorectal carcinoma, excision of	32105	fistula, ligation of cervical vessel/s	39812
application of formalin	32212	fistula, stenosis of, correction of	34518
examination, under GA	32171	malformation, excision of	45039,45042,45045
malformation, neonatal, laparotomy and colostomy	43822	malformation, intracranial artery clipping of	39806
malformation, paediatric, operations	43960,43963,43966	malformation, intracranial, excision of	39803
sensation, measurement of	11830	malformation, laminectomy, radical excision of	40318
Anorectoplasty of anorectal malformation	43963,43966	shunt, declotting of	13106
Antenatal cardiotocography (restriction)	16514	shunt, external, insertion/removal	34500,34506
care, independent of confinement	16500	Artery, anastomosis of, microvascular	45502
service provided by a midwife, nurse or registered Aboriginal Health Worker	16400	bypass grafting, occlusive arterial disease	32700-32763
Antepartum haemorrhage, treatment of	16509	coeliac, decompression of	34142
Anterior chamber, irrigation of blood from	42743	coronary, bypass operations	38497-38504
resection of rectum	32024,32025	embolectomy of	33800,33803,33806
section of corpus callosum for epilepsy	40700	endarterectomy of	33500-33542
synechiae, division of	42761	ethmoidal, transorbital ligation of	41725
vaginal repair	35570-35573	great, ligation/exploration, other	34103
Antireflux operations	30527,30529,30530	harvesting for coronary bypass	38496
operation by fundoplasty	31464,31466	ligation/exploration not otherwise covered	34106
Antrectomy and/or vagotomy	30497,30503	major, of neck, ligation/exploration, other	34100
Antrobuccal fistula operation	41722	major, repair of wound of	33815-33839
Antroscopy of temporomandibular joint	45855,45857	maxillary, transantral ligation of	41707
		neck, reoperation for bleeding/thrombosis	33842

* Payable on attendance basis

Service	Item	Service	Item
patch grafting to popliteal, exploration for popliteal entrapment	33545,33548	Atresia, choanal, repair/correction	45645,45646
temporal, biopsy of	34109	external auditory canal, reconstruction	45662
thrombectomy of	33803,33806	Atrial chamber/s, operations for arrhythmia	38512,38515
Arthroctomy, hip	49309,49312	septal defect closure, surgical	38742
rotational,coronary artery	38309-38318	septal defect closure, transcatheter approach	38272
Arthrocentesis. with irrigation of temporomandibular joint	45865	septectomy	38739
Arthrodesis, ankle	49712	Attendance, acupuncture	173-195
elbow	49106	Case Conference, Consultant Psychiatrist	855-866
finger/hand	46300,46303	acupuncture	173-199
foot	49815,49845	antenatal	16500
hip	49306	care planning	721-731
joint, other	50109	case conference - consultant psychiatrist	855-866
knee	49509,49512,49545	case conference, consultant physician	820-838
sacro-iliac joint	49300	case conferencing	740-773
shoulder	48939,48942	consultant occupational physician	385-388
subtalar joint	50118	consultant physician (not psychiatry)	110-131
wrist	49200,49203	consultant physician treatment and management plan	132-133
Arthroplasty, ankle	49715	consultant psychiatrist	300-352
carpal bone	46324,46325	consultant public health medicine	410-417
finger/hand	46306-46321	contact lenses	10801-10816
foot	49839,49842	emergency - after hours	1,2,97,98
hip	49309-49333,49346	emergency - after hours (11pm to 7am)	601,602,697,698
joint, other	50127	emergency physician	501-536
knee	49518-49534	family group therapy	170,171,172
shoulder	48915-48924	focussed psychological strategies	2721-2727
temporomandibular joint	45758	general practitioner	1-51
wrist	49209	general practitioner, emergency, after hours	1,2
Arthroscopy, ankle	49700,49703	geriatrician comprehensive assessment and management plan	141-147
elbow	49118,49121	health assessments	700-706
hip	49360,49363,49366	incentive items - PIP - general practitioner	2501-2559
joint, other	50100,50102	incentive items - PIP - other non-preferred	2600-2677
knee	49557-49566	intensive care unit (specialist)	13870,13873
shoulder	48945-48960	other non-specialist	52-98
wrist	49218-49227	other non-specialist, emergency, after hours	97,98
Arthrotoomy, ankle	49706	post-operative	(see note T8.7)
elbow	49100	prolonged, lifesaving treatment	160-164
finger/hand	46327,46330	public health physicians	410-417
hip	49303	specialist	104-108
joint, other	50103	sports physicians	444-449
knee	49500	telepsychiatry	353-370
shoulder	48912	Atticotomy	41533,41536
wrist	49212	Audiogram	11309-11318
Artificial erection device, insertion of	37426,37429	impedance	11324,11327,11330
erection device, revision or removal of	37432	Audiometry, brain stem evoked response	11300
insemination services	13203,13209,13221	non-determinate	11306
lens, insertion of	42701	oto-acoustic emission audiometry	11332
lens, removal of	42704	Auditory canal, external	41524
lens, removal, replacement different lens	42707	- reconstruction of	
lens, repositioning of, open operation	42704	- reconstruction, congenital atresia	45662
urinary sphincter, insertion	37381,37384,37387	- removal of foreign body, incision	41503
urinary sphincter, revision/removal	37390	canal external, blind sac closure	41564
Arytenoidectomy with microlaryngoscopy	41867	canal stenosis, correction of, with meatoplasty	41521
Aspiration biopsy, bone marrow	30087	meatus, external, removal of exostoses in	41518
biopsy, deep organ, imaging guided	30094	meatus, internal, exploration	41599
of bladder, needle	37041	Augmentation mammoplasty	45524,45527,45528
of breast cyst	*	Aural polyp, removal of	41506
of haematoma	30216	Autoconjunctival transplant	42641
of joint, other synovial cavity (restriction)	50124,50125	Avulsion, penis, repair of	37411
of thoracic cavity	38800,38803	Axilla, lymph glands, excision of	30332
one or more jaw cysts	45799	lymph nodes, excision of	30335,30336
Assistance at operations	51300-51318	Axillary hyperhidrosis, excision for	30180,30183
Assisted reproductive technologies	13200-13221	to femoral bypass grafting	32715
Atherectomy, peripheral arterial	35312	vessel, ligation/exploration, other	34103
		Axillofemoral graft, infected, excision of	34172

* Payable on attendance basis

Service	Item	Service	Item
abdominal aortic aneurysm, endovascular repair	33116,33119	excision of	37000,37014
angiography, selected coronary	38215-38246	exstrophy closure	37050
		exstrophy of, repair of	37842
		neck reconstruction, prostatectomy	37210,37211
		neck resection, endoscopic	36854
		repair of rupture	37004
		stress incontinence, Stamey or similar	37043
		stress incontinence, sling procedure	37042
		stress incontinence, suprapubic procedure	37044
		transection, with re-anastomosis to trigone	37053
		tumour/s, diathermy/resection	36845,36840
		tumour/s, laser destruction with cystoscopy	36840
		washout test of	11921
		Block, nerve, regional or field	(see nerve)
		Blood, administration of	13703,13706
		arterial, collection for pathology	13839,13842
		collection of, for transfusion	13709
		collection of, in infants, for pathology	13312
		dye - dilution indicator test	11715
		peripheral, invitro processing, cryopreservation	13760
		pressure monitoring, indwelling catheter	11600
		pressure monitoring, indwelling catheter (ICU only)	13876
		retrograde admin for cardioplegia	38588
		sampling, fetal	16606
		transfusion	13703,13706
		transfusion, fetal	16609-16615
		transfusion, paediatric/neonatal	13306,13309
		volume estimation, nuclear	12500
		Bone, cysts, injection into or aspiration of	47900
		bone conduction hearing system	41603,41604
		densitometry	12306-12321
		excision of, with melanoma	31340
		flap, infected, craniectomy for	39906
		graft to femur	48200,48203
		graft to humerus	48212,48215
		graft to other bones	48239
		graft to phalanx or metacarpal	46402,46405
		graft to radius and ulna	48221
		graft to radius or ulna	48218,48224,48227
		graft to scaphoid	48230,48233,48236
		graft to spine	48642-48651
		graft to tibia	48206,48209
		graft, harvesting of	47726,47729,47732
		graft, with internal fixation	48242
		growth stimulator	45821
		lesion/s, removal, diaphyseal aclasia	50426
		marrow, administration of	13706
		marrow, aspiration biopsy of	30087
		marrow, harvesting of for transplantation	13700
		marrow, in vitro processing/cryopreservation	13760
		tumour, benign, resection of	50230
		tumour, innocent, excision of	30241
		tumour, malignant, operations for	50200-50239
		Botulinum toxin, injection for	18350-18373
		arm spasticity, post-stroke	18360
		blepharospasm	18370-18373
		cervical dystonia (spasmodic torticollis)	18352
		dynamic equinovagous	18358
		dynamic equinovarus	18356
		dynamic equinus foot deformity	18354
		focal spasticity	18360
		foot deformities due to spasticity	18354-18358
		hemifacial spasm	18350,18351
		hyperhydrosis	18362

* Payable on attendance basis

Service	Item	Service	Item
Capsule endoscopy, for obscure gastrointestinal bleeding	11820	central vein, subcutaneous tunnel	34527,34528
Capsule, posterior, needling of	42737	central vein, tunnelled cuffed	34538
Capsulectomy	42719,42722,42731	eustachian tube	41755
of finger joints	46336	frontal sinus	41740
Capsulotomy, laser	42788,42789	intracranial, for pressure monitoring	13830
other than laser	42734	peripheral arterial	35317-35321
Carbolisation of eye	*	peripheral venous	35317,35319,35320
Carbon dioxide laser resurfacing, face or neck	45025,45026	peritoneal, for dialysis	13109,13110
dioxide output, estimation of	11503	pulmonary artery	13818
labelled urea breath test	12533	right heart balloon	13818
Carbuncle, incision and drainage, with GA	30223	umbilical artery	13303
Carcinoma	(see tumour)	umbilical or scalp vein in a neonate	13300
Cardiac by-pass, whole body perfusion	22060	ureteric, with cystoscopy	36824
catheterisation	38200-38218	Caudal infusion/injection	(see Intrathecal)
catheterisation - for myocardial biopsy	38275	Cauterisation, angioma (restriction applies)	45027
deep hypothermic circulatory arrest	22075	cervix	35608
electrophysiological studies	38209,38212,38213	perforation of tympanum	41641
operation (intrathoracic), other	38456	septum/turbinates/pharynx	41674
pacemaker, insertion/replacement	38353	tarsus, for ectropian/entropian	42581
resynchronisation therapy	38365,38368,38654	urethra or urethral caruncle	35523
38371		Cautery, conjunctiva, including treatment of pannus	42677
rhythm, restoration, electrical stimulation	13400	nasal, for arrest of haemorrhage	41677
surgery, for congenital heart disease	38700-38766	Cavernous sinus, tumour or vascular lesion, excision	39660
surgery, re-operation via median sternotomy	38640	Cavopulmonary shunt, creation of	38733,38736
tumour, excision of	38670-38680	Cellulitis, incision with drainage, under GA	30223
Cardiopexy, antireflux operation	30530	Central cannulation for cardiopulmonary bypass	38600
Cardioplegia, retrograde administration of	22070	nervous system evoked responses	11024,11027
Cardiopulmonary bypass, cannulation for	38600,38603	vein catheterisation	13318,13319,13815
support procedures	13815-13857	vein catheterisation, via subcutaneous tunnel	34527,34528
Cardiotocography, antenatal (restriction)	16514	Cerebello-pontine angle tumour	41575-41579
Cardioversion	13400	- retromastoid removal of	41575-41579
Care planning	721-731	- translabyrinthine removal	41575-41579
Carotid artery, aneurysm, graft replacement	33100	- transmastoid removal	41575-41579
artery, internal, transection/resection	32703	Cerebral palsy, hips or knees, application of cast under GA	50390
body tumour, resection of	34148,34151,34154	perfusion, retrograde, cannulation for	38577
cavernous fistula, obliteration of	39815	single event multilevel surgery	50450-50476
percutaneous transluminal angioplasty with stenting	35307	tumour, craniotomy for removal	39712
Carpal bone, replacement arthroplasty	46324,46325	ventricle, puncture of	39006
ligament, transverse, division of	39331	Cerebrospinal fluid drain, lumbar, insertion of	40018
resection arthroplasty	46325	fluid reservoir, insertion of	39018
scaphoid, fracture, treatment of	47354,47357	Cervical decompression of spinal cord	40331-40335
tunnel release	39331	discectomy (anterior), without fusion	40333
Carpometacarpal joint, arthrodesis of	46303	oesophagectomy	30294
joint, dislocation, treatment of	47030,47033	oesophagostomy, closure or plastic repair of	30293
joint, synovectomy of	46342	re-exploration for hyperparathyroidism	30317
Carpus dislocation, treatment of	47030,47033	rib, removal of	34139
fracture, treatment of	47348,47351	sympathectomy	35003,35006
operation on, acute osteomyelitis	43503,46462	Cervix, amputation or repair of	35617,35618
operation on, chronic osteomyelitis	43512,46462	cauterisation of, other than by chemical means	35608
osteectomy/osteotomy of	48406,48409	colposcopic examination of	35614
Caruncle, urethral, cauterisation of	35523	colposcopy with biopsy and diathermy	35646
urethral, excision of	35526,35527	cone biopsy of	35617,35618
Case conferencing	740-773	diathermy of	35608,35646
geriatrician or rehabilitation physician	880	electrocoagulation diathermy	35644,35645
Cataract, juvenile, removal of	42716	ionisation of	35608
surgery	42702	large loop excision	35647,35648
Catheter, peritoneal insertion and fixation	13109	laser therapy (restriction applies)	35539,35542,35545
epidural, insertion of	39140	punch biopsy	35608
placement of catheters and injection of opaque material	38243	purse string ligation	16511
tenckhoff peritoneal dialysis, removal of	13110	removal of polyp from	35611
Catheterisation, bladder, independent procedure	36800	removal of purse string ligature	16512
blood pressure monitoring	13876	repair of extensive laceration/s	16571
cardiac	38200-38218	repair of, not otherwise covered	35617,35618
central vein	13318,13319,13815	residual stump, removal of, abdominal approach	35612

* Payable on attendance basis

Service	Item	Service	Item
residual stump, removal of, vaginal approach	35613	total, with ileo-rectal anastomosis	32012
Chalazion, extirpation of	42575	total, with ileostomy	32009
Chemical peel, full face	45019,45020	Colles' fracture of radius, treatment of	47369,47372,47375
Chemotherapy	13915-13936	treatment of paediatric	50508-50512
device for drug delivery, loading of	13939,13942,13945	Colonic atresia, neonatal, laparotomy for	43816
device, insertion, central vein catheterisation	34527,34528	lavage, total, intra-operative	32186
device, removal of	34530	reservoir, construction of	32029
infusion, cannulation for	34521,34524	Colonoscopy, fibreoptic	32084-32093
Chest, or limb, decompression escharotomy	45054	Colorectal strictures, endoscopic dilatation of	32094
Chloasma, full face chemical peel	45019,45020	Colostomy, closure of	30562
Choanal atresia, repair/correction	45645,45646	colostomy	30375
Cholangiogram, percutaneous transhepatic	30440	entero-	30515
Cholangiography, operative	30439	lavage of	*
Cholangiopancreatography	30484	refashioning of	30563
Cholecystectomy	30443-30449	with laparotomy, neonatal anorectal malformation	43822
Cholecystoduodenostomy	30460,31472	Colotomy	30375
Cholecystoenterostomy	30460,31472	Colour discrimination test, Farnsworth Munsell	*
Cholecystostomy	30375	Colpoperineorrhaphy	35571,35573
Choledochal cyst, resection of	43972,43975	Colpopexy, sacral	35597
Choledochoduodenostomy	30460,30461	sacrospinous	35568
Choledochoenterostomy	30460,30461	Colposcopy, using Hinselmann-type instrument	35614
Choledochogastrostomy	30461	with other procedures	35644-35647
Choledochojejunostomy	30460,30461	Colpotomy	35572
Choledochoscopy	30442,30452	Composite graft to nose, ear or eyelid	45656
Choledochotomy	30454,30455,30457	Computerised perimetry	11221-11225
Chondro-cutaneous or chondro-mucosal graft	45656	Condylectomy	45611,48406,48424
Chondroplasty of knee	49503,49506	of mandible	45611
Chordee, correction of	37417	Condylectomy/condylotomy	45863
Chorionic villus sampling	16603	Cone biopsy of cervix	35617,35618
Chymopapain (Discase), intradiscal injection of	40336	Confinement	16515-16525
Cicatricial flexion/extension contracture, joint, correction	50112	Congenital absence of vagina, reconstruction for	35565
Ciliary body and/or iris, excision of tumour	42767	atresia, auditory canal reconstruction	45662
Circulatory support device, management of	13851,13854	heart disease, operations for	38700-38766
support procedures	38600-38624	Conjunctiva, cautery of	42677
Circumcision	30653-30660	biopsy of	42676
arrest of post-operative haemorrhage	30663	cryotherapy to	42680
- with GA		removal of tumour from	(see tumour,other)
- without GA	*	Conjunctival cysts, removal of	42683
Cisternal puncture	39003	graft over cornea	42638
shunt diversion, insertion of	40003	lacerations not involving sclera	30032
shunt, revision or removal of	40009	peritomy	42632
Clavicle, dislocation, treatment of	47003,47006	Conjunctivorhinostomy	42629
fracture, treatment of	47462,47465	Consultation	(see attendances)
operation for acute osteomyelitis	43503	Contact lenses, attendances	10801-10816
operation for chronic osteomyelitis	43512	Contour reconstruction, insertion of foreign implant	45051
osteotomy/osteotomy	48406,48409	restoration of face, autologous bone/cartilage graft	45647
Claw toe, correction of	49848	Contraceptive device, intra-uterine, introduction of	35503
Cleft lip, operations for	45677-45704	device, intra-uterine, removal under GA	35506
palate, correction of	45707,45710,45713	Contracted socket, reconstruction	42527
Clitoris, amputation of, medically indicated	35530	Contracture, cicatricial flexion/extension of joint, correction	50112
Clitoroplasty, reduction, ambiguous genitalia	37845,37848	Dupuytren's, subcutaneous fasciotomy for	46366
Clival tumour, removal of	39653-39658	flexor/extensor, digits of hand, correction of	46492
Cloaca, persistent, correction of	43969	Cordotomy, laminectomy for	39124
Cloacal exstrophy, neonatal, operation for	43882	percutaneous	39121
Club hand, radial, centralisation/radialisation	50399	Cornea, conjunctival graft over	42638
Coccyx, excision of	30672	epithelial debridement for corneal ulcer/erosion	42650
Cochlear implant, insertion with mastoidectomy	41617	epithelial debridement for keratoplasty	42651
tests	11318,11321	removal of imbedded foreign body	42644
Cochleotomy, or repair of round window	41614	removal of superficial foreign body	30061
Coeliac artery, decompression of	34142	transplantation of	42653,42656,42659
Colectomy, subtotal, of large intestine	32004,32005	Corneal, laser coagulation of blood vessels	42797
total, for Hirschsprung's, paediatric	43996	additional incisions for astigmatism	42673
total, with excision rectum/anastomosis	32051,32054,32057	incisions for astigmatism	42672
total, with excision rectum/ileostomy	32015,32018,32021	keratoplasty, epithelial debridement for	42651

* Payable on attendance basis

Service	Item	Service	Item
perforations, sealing of	42635	breast, aspiration of	*
scars, excision of	42647	broad ligament, excision of	35712-35717
suture, running, manipulation of	42667	bronchogenic, thoracotomy and excision	43912
sutures, removal of	42668	choledochal, resection of	43972,43975
ulcer, epithelial debridement of cornea for	42650	enterogenous, thoracotomy and excision	43912
ulcer, ionisation of	*	epididymal, removal of	37601
Coronary artery bypass operations	38497-38504	fimbrial, excision of	35712-35717
angiography, selective	38215-38246	hydatid, liver, treatment of	30434-30438
artery bypass vein graft, dissection	38637	hydatid, lungs, enucleation of	38424
endarterectomy, open operation	38505	intracranial, needling and drainage of	39703
restenoses, catheter based intravascular brachytherapy	15360,15363,1554	kidney, removal from	36558
38321,38324,38327,38330		liver, laparoscopic marsupialisation	30416,30417
Coronary pressure wire	38241	mucous, of mouth, removal	30282,30283
Corpus callosum, anterior section of, for epilepsy	40700	not otherwise covered, removal of (OMS)	45801-45809
Corticectomy, for epilepsy	40703	other, removal of	31200-31240
Corticolysis of lens material	42791,42792	ovarian, aspiration of	35518
Costo-transverse joint, injection into	39013	ovarian, excision of, with laparotomy	35712-35717
Counterpulsation, intra-aortic balloon, management	13848,13847	pancreatic, anastomosis	30586,30587
Cranial nerve, intracranial decompression of	39112	parovarian, excision of, with laparotomy	35712-35717
shunt diversion, insertion of	40003	pharyngeal, removal of	41813
shunt, revision or removal of	40009	pilonidal, excision of	30675,30676
vault reconstruction	45785	renal, excision of	36558
Craniectomy and removal of haematoma	39603	skin/subcutaneous/mucous membrane, removal of	31200-31240
for osteomyelitis/removal infected bone	39906	tarsal, extirpation of	42575
Cranio-cervical junction lesion, transoral approach for	40315	thyroglossal, removal of	30313,30314
Craniopharyngioma, craniotomy for removal of	39712	vaginal, excision of	35557
Cranioplasty and repair of fractured skull	39615	vallecular, removal of	41813
reconstructive	40600	Cystadenomatoid malformation, neonatal, thoracotomy	43861
Cranio-stenosis, operations for	40115,40118	Cystocoele, repair of	35570
Craniotomy and tumour removal	39709,39712	Cystometrography	11903
burr-hole for intracranial haemorrhage	39600	with other procedures	11912,11915,11917
for arachnoidal cyst	39718	11919	
for hydromyelia (with laminectomy)	40342	Cystoscopy, with	36836
for reopening post-op for haemorrhage/swelling	39721	- biopsy of bladder	
Cricopharyngeal myotomy	41776	- controlled hydrodilataion of bladder	36827
Cricothyrostomy	41884	- diathermy or resection of bladder tumour/s	36845
Cruciate ligaments, reconstruction/repair	49536,49539,49542	- endoscopic incision/resection	36825,36854
Cryotherapy for detached retina	42773	- injection into bladder wall	36851
for trichiasis	42587	- insertion of ureteric stent, or brush biopsy	36821
hepatic, destruction of liver tumours	30419	- insertion of urethral prosthesis	36811
of peripheral nerves	39323	- laser destruction of bladder tumours	36840
of retina, with vitrectomy	42728	- lavage of blood clots from bladder	36842
of skin lesions	30189,30192,30195	- removal of foreign body	36833
to haemorrhoids with rubber band ligation	32135	- resection of ureterocele	36848
to nose, for haemorrhage	41680	- ureteric catheterisation	36818,36824
to retina, independent procedure	42818	- ureteric meatotomy	36830
Crystalloid, retrograde admin for cardioplegia	38588	- urethroscopy with/without urethral dilatation	36812
Curettag, for evacuation of gravid uterus	35643	- without litholapaxy	36863
uterus (D and C)	35639,35640	- without urethroscopy	36815
Cutaneous neoplastic lesions, treatment of	30195	Cystostomy, suprapubic	37008
nerve, nerve graft to	39318	suprapubic, change of tube	*
nerve, repair of	39300,39303	Cystotomy, suprapubic	37008,37011
ureterostomy, closure of	36621	Cytotoxic agent, instillation into body cavity	13948
vesical fistula, operation for	37023	cauterisation of, for ectropion or entropion	42581
vesicostomy, establishment of	37026	coalition, excision of	50333
Cyclodestructive procedures treatment of glaucoma	42770,42771	cyst, extirpation of	42575
Cyst, arachnoidal, craniotomy for	39718		
Baker's, excision of	30114		
Bartholin's, cautery destruction of	35516,35517		
Bartholin's, excision of	35512,35513		
Bartholin's, marsupialisation of	35516,35517		
bone, injection into or aspiration of	47900		
brain, operations for	39703		
branchial, removal of	30286		
		D	
		D and C	35639,35640
		Dacryocystectomy	42596
		Dacryocystorhinostomy	42623,42626
		Dark Adaptometry	11211
		Debridement of contaminated wound	30023

* Payable on attendance basis

Service	Item	Service	Item
of tissue, ischaemic limb	35100,35103	lumbar intervertebral, total artificial replacement	48691-48693
Debulking operation, gynaecological malignancy	35720	Discectomy, cervical (anterior), without fusion	40333
Decompression fasciotomy, calf/forearm	47975,47978,47981	microsurgical, of intervertebral disc/s	40301
fasciotomy, hand	47981	percutaneous lumbar	48636
of Arnold-Chiari malformation	40106	Disimpaction of faeces under GA	32153
of facial nerve, mastoid portion	41569	Dislocations, treatment of	(see body part)
of intracranial tumour	39706	Dissection, lymph nodes of neck	31423-31438
operation for priapism	37393	Diverticulum, bladder, excision/obliteration	37020
subtemporal	40015	Meckel's, removal of	30375
Deep organ, percutaneous aspiration biopsy	30094	urethral, excision of	37372
tissue or organ, biopsy of	30074,30075,30078	Dohleman's operation	41773
Defibrillator generator, insertion/replacement	38393	Domiciliary Medication Management Review	900
insertion of patches for	38390	Donald-Fothergill operation	35577
Delorme procedure	32111	Donor haemapheresis	13755
Dermabrasion	45021,45024	Doppler recordings	11612,11602,11610
Dermo-fat or fascia graft	45018	11611,11614	
Dermoid, excision of	(see tumour,other)	Double balloon enteroscopy	30680-30686
nasal, excision of	41729	Double vagina, excision of septum	35566
oral and maxillofacial region	45801-45807	Drez lesion, operation for	39124
orbital, excision of	42574	Drill biopsy of lymph gland/deep tissue/organ	30078
periorbital, excision of	42573	Drug delivery device, loading of	13939,13942,13945
Detached retina, diathermy/cryotherapy	42773	drug delivery system for spasticity management	14227-14242
retina, removal of silicone band	42812	Duct, salivary gland, diathermy/dilatation	30262
retina, resection/buckling/revision	42776	salivary gland, major, transposition of	41910
Dialysis, peritoneal	13112	salivary gland, marsupialisation	30265,30266
supervision in home	13104	salivary gland, meatotomy	30265,30266
supervision in hospital	13100,13103	salivary gland, removal of calculus	30265,30266
Diaphragm, plication of for eventration	43915	Ducts submandibular, removal of	30255
Diaphragmatic hernia, neonatal, repair of	43837,43840	Duodenal atresia, duodeno-duodenostomy/jejunostomy	43807
hernia, repair of	30600,30601	intubation	30487,30488
hernia, simple closure of	30387	stenosis, duodeno-duodenostomy/jejunostomy	43807
Diaphyseal aclasia, removal of lesion/s from bone	50426	ulcer, perforated, suture	30375
Diastematomyelia, tethered cord, release of	40112	Duodenoduodenostomy for duodenal atresia/stenosis	43807
Diathermy of bladder tumours	36845,36840	Duodenojejunostomy for duodenal atresia/stenosis	43807
cervix	35608,35646	Duodenoscopy	30473,30476,30478
detached retina	42773	Dupuytren's contracture, operations for	46366-46393
electrocoagulation, of cervix	35644,35645	Dysthyroid eye disease, decompression of orbit	42545
palmar or plantar wart	30186	device for delivery of therapeutic agents	14221-14242
perforation of tympanum	41641	drug delivery system	39125,39126,39128
pharynx	41674	39133	
rectal polyps with sigmoidoscopy	32078	drug delivery system for spasticity management	14227-14242
salivary gland duct	30262	loop recorder for investigation of syncope	11722
septum	41674	pace maker testing	11718-11721
starburst vessels, head or neck	30213,30214	pump or reservoir, loading of	14218
telangiectases, head or neck	30213,30214	reservoir associated with adjustable gastric band	14215
turbinates	41674		
urethra	37318		
Diffusing capacity	11503		
Digit, amputation of	46464-46480		
distal, excision of ganglion/mucous cyst	46495	E.C.G.	11700-11713
extra, amputation of	46464	E.C.T.	14224
flexor/extensor contracture, correction of	46492	E.E.G.	11000,11003,11006
or ray, transposition/transfer, vascular pedicle	46507	11004,11005	
synovectomy of tendon/s	46348-46360	E.M.G.	11012,11021,11833
transposition/transfer, vascular pedicle	46507	E.N.G.	11339
Digital nail, toe, removal of	47904,47906	ESWL	36546
nerve, nerve graft to	39318	Ear, composite graft to	45656
nerve, repair of	39300,39303	drum perforation, excision of rim	41644
temperature, measurement of	11615	external, complex total reconstruction of	45660,45661
Direct flap repair	45209-45224	full thickness laceration, repair of	30052
Disarticulation, of limb	(see amputation)	full thickness wedge excision of	45665
Disc, intervertebral, laminectomy for removal	40300	lop, bat or similar deformity, correction of	45659
intervertebral, microsurgical discectomy of	40301	middle, clearance of	41635,41638
lesion, recurrent, laminectomy for	40303	middle, exploration of	41629
		middle, insertion of tube for drainage of	41632

* Payable on attendance basis

Service	Item	Service	Item
middle, operation for abscess or inflammation of	41626	Endometriosis, laparoscopic ablation	35638
removal of foreign body from	41500,41503	Laparoscopic resection of	35641
syringe of	*	Endometrium, ablation of, endoscopic	35622
toilet, using operating microscope	41647	ablation of, by radiofrequency electrosurgery	35616
ventilating tube, removal	*	biopsy of	*
Eclampsia, treatment of	16509	biopsy of for suspected malignancy	35620
Ectopic bladder, 'turning-in' operation	37842	biopsy of with hysteroscopy	35630
pregnancy, removal of	35676,35677,35678	biopsy of, with IUD insertion for idiopathic menorrhagia	35502
pregnancy, ultrasound guided needling and injection	35674	endoscopic examination and ablation by microwave or thermal	
Ectropion, correction of	45626	balloon	35616
tarsal cauterisation for	42581	Endoscopic biliary dilatation	30494
Elbow, arthrodesis of	49106	cholangio-pancreatography	30484
arthroscopic surgery of	49121	dilatation of colorectal strictures	32094
arthroscopy of, diagnostic	49118	examination of intestinal conduit/reservoir	36860
arthrotomy of	49100	examination of small bowel	30569,32095
dislocation, treatment of	47018,47021	gastrostomy, percutaneous	30481,30482
flexorplasty/tendon transfer to restore function	50405	incision/resection, external sphincter/bladder neck	36854
ligamentous stabilisation of	49103	laser ablation of prostate	37207,37208
radial head, replacement of	49112	laser resection of endobronchial tumours	41901
revision arthroplasty	49116,49117	laser therapy of gastrointestinal tract	30479
total replacement of	49115	manipulation/extraction of ureteric calculus	36857
total synovectomy of	49109	prostatectomy	37203,37206
Electrical stimulation, maximal perineal	*	resection of pharyngeal pouch	41773
stimulation, restoration cardiac rhythm	13400	sphincterotomy	30485
Electrocardiography	11700-11713	stenting of bile duct	30491
Electrocochleography	11303,11304	transanal endoscopic microsurgery	32103,32104,32106
Electroconvulsive therapy	14224	ultrasound	30688-30694
Electrocorticography	11009	Endoscopy with balloon dilatation gastric stricture	30475
Electrode(s), epidural, insertion by laminectomy	39139	capsule, for obscure gastrointestinal bleeding	11820
epidural, percutaneous insertion of	39130	Enterocoele, repair of	35571
epidural, percutaneous, management of	39131	Enterocolitis, acute neonatal necrotising, laparotomy	43828,43831
graciloplasty, insertion of	32206	necrotising stricture, bowel resection	43834
intracranial placement	40709,40712	Enterocolostomy	30515
myocardial, permanent, insertion, thoracotomy	38470	Enterocutaneous fistula, radical repair of	30382
pacemaker, permanent, insertion sub xyphoid	38473	Enterostomy	30515
transvenous, insertion of	38256,38356	Enterostomy, closure of	30562
Electrodiagnosis, neuromuscular	11012-11021	enterostomy	30375
Electroencephalography (E.E.G)	11000,11003,11006	Enterotomy, intra-operative, for endoscopy	30568
11004,11005		enterotomy	30375
Electrolysis epilation, for trichiasis	42587	Entropion, correction of	45626
Electromyography (E.M.G.)	11012,11021,11833	repair of	42866
Electroneurography of facial nerve	11015	Enucleation of eye	42506,42509
Electronystagmography (E.N.G.)	11339	hydatid cysts of lung	38424
Electrooculography	11205	Epicondylitis, open operation for	47903
Electrophysiological studies, cardiac	38209,38212,38213	Epicutaneous patch testing	12012-12021
Electroretinography	11204,11205,11210	Epididymal cyst, excision of	37601
Embolectomy	33803,33806	Epididymectomy	37613
Embolus, removal from artery of neck	33800	Epidural blood patch	18233
Emergency, after hours	1,2,97	catheter, insertion of	39140
98		electrode, insertion	39130,39139
Emergency, after hours (11pm to 7am)	601,602,697,698	electrode, management, adjustment etc.	39131
Emphysema, lobar, neonatal, thoracotomy & lung resection	43861	implant, removal of	39136
Empyema, intercostal drainage of	38806,38809	infusion/injection	(see Group T7)
radical operation for	38415	stimulator, revision of	39133
Enbloc resection of tumour	50212-50227	Epigastric hernia, repair of	30616-30621
Encephalocele, excision and closure of	40109	Epilation electrolysis, for trichiasis	42587
Endarterectomy	33500-33542	Epilepsy, operations for	40700-40712
coronary, open operation	38505	Epiphyseal arrest	48500-48509
to prepare bypass site for anastomosis	33554	plate, prevention of closure	48512
Endobronchial tumour, endoscopic laser resection	41901	Epiphysiodesis, femur/fibula/tibia	48500,48503,48506
Endocarditis, operative management of	38493	staple arrest of hemi-epiphysis	48509
Endocrine tumour, exploration of	30578,30580,30581	Epiphysiodesis, to prevent closure of plate	48512
Endolymphatic sac, transmastoid decompression	41590	Epispadias, repair of	37836,37839,37842
Endometrial biopsy for suspected malignancy	35620	Epistaxis, treatment of	41656,41677,41680

* Payable on attendance basis

Service	Item	Service	Item
Epithelial debridement for corneal ulcer/erosion	42650	radioactive plaques, construction,insertion & removal	42801,42802
debridement/eliminating band keratoplasty	42651	tantalum marker, insertion and removal	42805
Ergometry, with electrocardiography	11712	trabeculoplasty, laser	42782
Erythrocyte radioactive uptake survival time	12503	vitreolysis, laser, of lens material	42791
screening test, volume Cr51	12500	Eyeball, repair of perforating wound	42551,42554,42557
Escharotomy, decompression, limb or chest		Eyebrow, elevation of	42872
Ethmoidal artery, transorbital ligation of	41725	Eyelashes, ingrowing, operation for	45626
sinuses, operation on	41737,41749	Eyelid closure in facial nerve paralysis, implant insertion	42869
Ethmoidectomy, fronto-nasal	41731	composite graft to	45656
fronto-radical	41734	ectropion or entropion, correction of	45626
transantral, with radical antrostomy	41713	full thickness laceration, repair of	30052
Etonogestral, subcutaneous implant, removal of	30062	full thickness wedge excision of	45665
Eustachian tube, catheterisation of	41755	grafting for symblepharon	45629
obliteration of	41564	ptosis, correction of	45623
Evacuation of retained products of conception	16564	reconstruction of, whole thickness	45614,45671,45674
Eventration, plication of diaphragm for	43915	reduction of	45617,45620
Evisceration of globe of eye	42512,42515	removal of cyst from	42575
Evoked response audiometry, brain stem	11300	tarsorrhaphy	42584
responses, central nervous system	11024,11027	upper recession of	42863
Exenteration of orbit of eye	42536	excision of, with melanoma	31340
Exomphalos, neonatal, operations for	43870,43873		
Exostoses in external auditory meatus, removal	41518	F	
Exostosis, excision of	47933,47936	Face, repair of complex fractures	45753,45754
mandibular or palatal	45825	chemical peel	45019,45020
Exstrophy, cloacal, neonatal, operation for	43882	Facet joint denervation by percutaneous neurotomy	39118
of bladder, closure	37050	Facial, nerve, decompression of	41569
of bladder, repair of	37842	nerve palsy, excision of tissue for	45581
Extensor tendon of hand or wrist, repair of	46420,46423	nerve paralysis, plastic operation for	45575,45578
tendon of hand, tenolysis of	46450	scar, revision of (restriction applies)	45506,45512
tendon, synovectomy of	46339	Facio-hypoglossal/accessory nerve, anastomosis of	39503
External auditory canal, reconstruction	45662,41524	Faecal incontinence, sacral nerve stimulation for	32213-32218
auditory meatus, removal of exostoses	41518	Fallopian tubes, catheterisation, with hysteroscopy	35633
cephalic version	16501	tubes, Rubin test for patency	35706
ear, complex total reconstruction of	45660,45661	tubes, hydrotubation of	35703,35709
fixation, orthopaedic, removal	47948,47951	tubes, implantation of, into uterus	35694,35697
stent, application	34824-34833	tubes, microsurgical anastomosis	35700
External cephalic version	16501	tubes, sterilisation	35687,35688
Extra digit, amputation of	46464	tubes, sterilisation with Caesarean section	35691
Extracardiac conduit, insertion/replacement	38757,38760	Falloscopy, unilateral/bilateral	35710
Extracorporeal shock wave lithotripsy	36546	Family group psychotherapy	342,344,346
Extracranial to intracranial bypass	39818,39821	group therapy	170,171,172
Extradural tumour or abscess, laminectomy for	40309	Farnsworth Munsell colour discrimination test	*
Eye, capsulotomy, laser	42788,42789	Fascia, deep, repair of, for herniated muscle	30238
carbolicisation of	*	graft	45018
coagulation, laser, of corneal/scleral blood vessels	42797	Fasciectomy, for Dupuytren's Contracture	46369-46393
conjunctiva, cautery of	42677	Fasciotomy, forearm or calf	47975,47978,47981
conjunctival graft	42638	interosseous muscle space of hand	47981
corticolysis, laser, of lens material	42791,42792	muscle	30226
dermoid, excision of	42573,42574	plantar, radical	49854
division of suture, laser	42794	subcutaneous, Dupuytren's contracture	46366
enucleation of	42506,42509,42510	Femoral hernia, repair of	30609,30612,30614
fibrinolysis	42791,42792	vein puncture in infants, blood collection	13312
foreign body in cornea or sclera, removal of	42644	vessel, ligation/exploration, other	34103
foreign body in, removal of	42560-42569	Femoro-femoral crossover bypass grafting	32718
foreign body in, superficial, removal of	30061	graft, infected, excision of	34172
globe of, evisceration of	42512	Femur, bone graft to	48200,48203
investigation of ocular surface dysplasia	11235	congenital deficiency, treatment of	50411,50414
iridotomy, laser	42785,42786	drill decompression of head/neck or both	47982
iris tumour, laser photocoagulation	42806	epiphyseodesis	48500,48506
laser photocoagulation	42806	fracture, treatment of	47516-47537,49336
orbit, insert/remove implant	42518	operation on, for osteomyelitis	43506,43515
paracentesis	42734	osteotomy/osteotomy	48424,48427
phototherapeutic keratectomy, laser	42810	Fetal blood sampling	16606
pinguecula, surgical excision	42689		

* Payable on attendance basis

Service	Item	Service	Item
fluid filled cavity, drainage of	16624	repair, direct	45209-45224
intra-peritoneal blood transfusion	16612,16615	repair, local, single stage	45200,45203,45206
intravascular blood transfusion	16609	repair, muscle, single stage	45000-45012
Feto-amniotic shunt, insertion of	16627	revision of, by incision and suture	45239
Fibreoptic bronchoscopy	41898	revision of, by liposuction	45240
colonoscopy	32084-32093	Flexor tendon, hand, repair of	46426-46435
Fibrinolysis	42791,42792	tendon pulley, reconstruction	46411
Fibroma, removal of	(see tumour,other)	tendon sheath, finger or thumb, open operation	46522
Fibula, congenital deficiency, transfer fibula to tibia	50423	tendon, hand, tenolysis of	46453
epiphyseodesis	48503,48506	tendon, hand/wrist, synovectomy of	46339
fracture, treatment of	47576	tendon, wrist, repair of	46426,46429
fracture, treatment of paediatric	50588	tendon/s, digit, synovectomy of	46348-46360
operation on, for osteomyelitis	43503,43512	Flexorplasty to restore elbow function	50405
osteotomy/osteotomy	48406,48409	Flow volume loops	11512
Field block	(see nerve)	Fluid Filled Cavity, drainage of	16624
Filtering and allied operations for glaucoma	42746	Fluid balance, supervision of	*
Fimbrial cyst, removal of	35712-35717	Foot, amputation or disarticulation of	44359,44361,44364
Finger, amputation of	46465-46483	and ankle, tibialis tendon transfer	50339,50342
digital nail, removal of	46513,46516	arthrodesis of	49815,49845
dislocation, treatment of	47036,47039	calcaneal spur, excision of	49818
flexor tendon sheath, open operation	46522	claw or hammer toe, correction of	49848,49851
fracture, treatment of	47300-47333	hallux valgus or hallux rigidus, correction of	49821-49842
ingrowing nail, resection of	46528,46531	metatarso-phalangeal joint, replacement of	49857
mallet, fixation/repair	46438,46441	metatarso-phalangeal joint, synovectomy of	49860,49863
percutaneous tenotomy of	46456	neurectomy for plantar digital neuritis	49866
trigger, correction of	46363	paronychia of, pulp space infection, incision	47912
Fissure in ano, operation for	32150	radical plantar fasciotomy or fasciectomy of	49854
Fistula, alimentary, repair of	35596	tendon of, repair of	49800,49803
anal, excision/repair	32159-32166	tendon or ligament transplantation of	49812
antrobuccol, operation for	41722	tenotomy of	49806,49809
aorto-duodenal, repair of	34160,34163,34166	tibialis tendon transfer	50339,50342
arteriovenous, dissection, ligation	34112,34115,34118	For anaesthesia	20100-25205
arteriovenous, dissection, repair	34121-34130	Foramen Magnum, tumour or vascular lesion, excision	39662
arteriovenous, ligation cervical vessel/s	39812	Forearm, amputation or disarticulation of	44328
branchial, removal of	30289	decompression fasciotomy of	47975,47978,47981
carotid-cavernous, obliteration of	39815	fracture, treatment of	47378-47393
cutaneous, salivary gland, repair of	30269	fracture, treatment of paediatric	50500-50548
enterocutaneous, radical resection	30382	radial aplasia/dysplasia, centralisation/radialisation	50399
genito-urinary, repair	35596	Foreign body, antrum, removal of	41716
in ano, subcutaneous, excision of	32156	bladder, cystoscopic removal of	36833
oro-antral, plastic closure of	41722	bronchus, removal of	41895
parotid gland, repair of	30269	cornea or sclera, imbedded, removal of	42644
sacrococcygeal, excision of	30675,30676	cornea or sclera, superficial, removal of	30061
thyroglossal, radical removal of	30314	ear, removal of	41500,41503
tracheo-oesophageal, division and repair	43900	implant, contour reconstruction, insertion	45051
urethral, closure of	37833	intra-ocular, removal of	42560-42569
urethro-rectal	37336	joint, removal of	(see arthrotomy)
urethro-vaginal	37333	maxillary sinus, removal of	41716
vesical, cutaneous, operation for	37023	muscle/deep tissue, removal of	30067,30068
vesico-intestinal, closure of	37038	nose, removal of	41659
vesico-vaginal, closure of	37029	oesophagus, removal of	41825
wound, review under GA, independent	32168	subcutaneous, removal of	30064
Fixation, external, removal of	47948,47951	superficial, removal of	30061
internal, of spine	48678-48690	tendon, removal of	30067,30068
Flap		trachea, removal of	41886
abbe	45701,45704	urethra, removal of	37318
direct, indirect or local, revision of	45239,45240	Fractures, treatment of	(see body part)
free tissue transfer, revision of	45496-45499	Free grafts	45400-45494
indirect	45227-45236	split skin, to burns	45460-45494
myocutaneous, delay of	45015	transfer of tissue	45563-45565
myocutaneous, for breast reconstruction	45530	transfer of tissue, anastomosis artery/vein	45502
neurovascular island	45563,46504	Frenulum, mandibular or maxillary, repair	30281
pharyngeal, for velo-pharyngeal incompetence	45716	Frontal sinus, catheterisation of	41740
repair - H-flap or double advancement	45207	sinus, intranasal operation on	41737

* Payable on attendance basis

Service	Item	Service	Item
sinus, radical obliteration of	41746	lacrimal, excision of palpebral lobe	42593
sinus, trephine of	41743	lymph, biopsy of	30074,30075
Fronto-ethmoidectomy, radical	41734	lymph, drill biopsy of	30078
Fronto-nasal ethmoidectomy	41731	lymph, pelvic, excision of	35551
Fronto-orbital advancement	45782,45785	lymph, pelvic, excision of, with hysterectomy	35664
Full thickness grafts, free	45451	parotid, superficial lobectomy/tumour removal	30253
thickness wedge excision of lip, eyelid or ear	45665	parotid, total extirpation of	30247,30250
Fundi, optic, examination of	11212	salivary, duct, dilatation or diathermy of	30262
Fundoplasty/plication, antireflux operation	30527,30529,30530	salivary, duct, marsupialisation	30265,30266
antireflux operation by	31464,31466	salivary, duct, meatotomy	30265,30266
Funnel chest, elevation of	38457,38458	salivary, duct, removal of calculus	30265,30266
Furuncle, incision with drainage of	30219,30223	salivary, operations on	30262-30269
Fusion, spinal, cervical/thoracic/lumbar	48660-48675	sublingual, extirpation of	30259
spinal, posterior interbody	48654,48657	submandibular, extirpation of	30256
vertebral body, diseases of	48640	Glaucoma, filtering and allied operations for	42746,42749
		Molteno valve, insertion of	42752
		Molteno valve, removal of	42755
		iridectomy and sclerectomy for	42746
		iridectomy or iridotomy	42764
		provocative tests for	11200
		tonography for, one or both eyes	11203
		Glenoid fossa, reconstruction of	45788
		Glioma, craniotomy for removal of	39709
		Globe of eye, evisceration of	42512,42515
		Glomus tumour, transmastoid removal of	41623
		tumour, transtympanic, removal of	41620
		Glossectomy, with partial pharyngectomy	41785
		Gonadal dysgenesis, vaginoplasty for	37851
		Goniotomy	42758
		Graciloplasty procedures	32200-32210
		Grafenberg's (or Graf) ring, introduction of	35503
		ring, removal under GA	35506
		Graft, axillo-femoral, infected, excision of	34172
		bone	(see bone)
		bypass, for occlusive arterial disease	32700-32763
		bypass, for treatment of aneurysm	(see aneurysm)
		composite (chondro-cutaneous/mucosal)	45656
		conjunctival over cornea	42638
		corneal	42653,42656,42659
		dermis, dermo-fat or fascia	45018
		femoro-femoral, infected, excision of	34172
		free fascia for facial nerve paralysis	45575,45578
		free, split skin	45400-45494
		inlay, using a mould	45445
		micro-arterial or micro-venous	45503
		nerve	39315,39318
		skin, to orbit	42524
		venous, to fenestration cavity	(see bypass)
		Grafting, bypass, occlusive arterial disease	(see aneurysm)
		bypass, treatment of aneurysm	(see aneurysm)
		for symblepharon	45629
		patch, to artery or vein	33545,33548
		Granuloma, cautery of	42677
		removal from eye, surgical excision	42689
		umbilical, excision under GA	43948
		Gravid uterus, evacuation of contents by curettage	35643
		Great vessel, intrathoracic operation on, other	38456
		vessel, ligation or exploration, other	34103
		Greater trochanter, transplant of ileopsoas tendon	50121
		Groin, lymph, excision of	30329,30330
		Grommet, free, in canal, removal of	*
		in situ in drum, removal of	41500
		insertion of	41632
		Group psychotherapy	342

* Payable on attendance basis

Service	Item	Service	Item
psychotherapy, family	342,344,346	osteectomy/osteotomy	46396,46399
therapy, family	170,171,172	paronychia/pulp space infection, incision for	46525
Gunderson flap operation	42638	tendon sheath, operation for tendovaginitis	46363
Gynaecological examination under GA	35500	tendon transfer for restoration of function	46417
Gynatresia, vaginal reconstruction for	35565	Hare lip	(see cleft lip)
H			
Haemangioma, cauterisation of (restriction)	45027	Hartmann's operation	32030
excision of	45030-45036	Health assessments	700-706
of neck, deep-seated, excision of	45036	Care planning	721-731
Haemapheresis	13750,13755	Case conferencing (other than Specialist or Cons Physician)	734-779
Haematoma, aspiration of	30216	Case conferencing by Consultant Physician	801-815
breast, exploration and drainage	31551	Case conferencing by geriatrician/rehabilitation physician	880
incision and drainage, without GA	30219	Heart arrhythmia, ablation of	38287,38290,38293
large, incision and drainage, with GA	30223	arrhythmia, surgery for	38512-38536
pelvic, drainage of	30387	catheterisation of	38200,38203,38206
Haemochromatosis	13757	electrical stimulation of	13400
Haemodialysis, in hospital	13100,13103	intrathoracic operation on, not otherwise covered	38456
central vein, tunnelled cuffed catheter	34538	mitral annulus, reconstruction after decalcification	38485
removal of tunnelled cuffed catheter	34539	subvalvular structures, reconstruction, re-implantation	38490
Haemofiltration, continuous (ICU)	13885,13888	surgery for congenital heart disease	38700-38766
in hospital	13100,13103	surgery, open, not otherwise covered	38653
Haemoperfusion, in hospital	13100,13103	valve replacement	38488,38489
Haemorrhage, antepartum, treatment of	16509	valve, repair	38480,38481
arrest of	*	Heller's operation	30532,30533
- following circumcision, with GA	30663	Hemiarthroplasty, hand	46309-46321
- following circumcision, without GA	*	knee	49517
- following tonsillectomy, with GA	41796,41797	Hemicircumcision, for hypospadias	37354
extremity, reoperation for control of	33848	Hemicolectomy	32000,32003,32006
intracranial, burr-hole craniotomy for	39600	Hemiepiphysis, staple arrest of	48509
nasal, arrest of	41656,41677	Hemifacial microsomia, construction condyle and ramus	45791
nasal, cryotherapy for treatment of	41680	Hemilaryngectomy, vertical, with tracheostomy	41837
post-op, control under GA, independent	30058	Hemispherectomy, for intractible epilepsy	40706
post-operative, following gynaecological surgery	35759	Hemithyroidectomy	30306
post-operative, laparotomy for	30385	Hemivulvectomy	35536
postpartum, treatment of	16567	Hepatic duct, common, resection for carcinoma	30463,30464
subdural, tap for	39009	artery catheterisation for SIRT	35406,35408
Haemorrhoidectomy	32138,32139	duct, common, repair of	30472
Haemorrhoids, injection into	*	ducts, Roux-en-Y bypass	30466,30467
removal of	32138,32139	metastases, selective internal radiation therapy for	35404-35408
rubber band ligation of	32135	Hepatocellular carcinoma	
sclerotherapy for	32132	destruction by radiofrequency ablation	50950,50952
Hair transplants, congenital/traumatic alopecia	45560	Hernia, antireflux operations for	30527,30529,30530
Hallux rigidus/valgus, correction of	49821-49842	diaphragmatic, neonatal, repair of	43837,43840
Halo, application	47711,47714	diaphragmatic, repair of	30600,30601
femoral traction, application of	47720,47723	diaphragmatic, simple closure of	30387
thoracic traction, application of	47717	femoral or inguinal, repair of	30609,30612,30614
Hammer toe, correction of	49848	inguinal, repair, age less than 3 months	44108,44111,44114
Hand, amputation or disarticulation of	44325,44328	spigelian, repair of	30403,30405
arthrotomy	46327,46330	strangulated, incarcerated or obstructed, repair of	30615
bone grafting for pseudarthrosis	46405	umbilical, epigastric, or linea alba, repair of	30616-30621
congenital abnormalities, amputation of phalanges	50396	ventral or incisional, repair of	30403,30405
congenital abnormalities, splitting of phalanges	50396	ventral, following closure exomphalos, repair of	43939
decompression fasciotomy	47981	Herniated muscle, fascia, deep, repair of	30238
digits, flexor/extensor contracture, correction	46492	Hiatus hernia, antireflux operations for	30527,30529,30530
duplication of digits, amputation of phalanges	50396	hernia, repair of	30601
duplication of digits, splitting of phalanges	50396	para-oesophageal, repair of	31468
extensor tendon of, repair of	46420,46423	Hickman catheter, insertion of, for chemotherapy	34527,34528
extensor tendon of, tenolysis of	46450	catheter, removal of	34530
flexor tendon of, repair of	46423-46435	High dose rate brachytherapy	37227
flexor tendon of, tenolysis of	46453	Hindquarter, amputation or disarticulation of	44373
ganglion, excision of	46494	Hinselmann colposcope, examination uterine cervix	35614
middle palmar/thenar/hypothenar spaces, drainage	46519	Hip, amputation or disarticulation at	44370
		arthrectomy	49309,49312
		arthrodesis	49306
		arthroplasty	49309-49346

* Payable on attendance basis

Service	Item	Service	Item
arthroplasty, revision	49346	laparoscopically assisted	35750-35756
arthroscopy	49360,49363,49366	with ovarian transposition, malignancy	35729
arthrotomy	49303	Hysteroscopic resection of myoma or uterine septum	35623,35634
congenital dislocation, open reduction	50351	resection of uterine septum	35634
contracture of, medial/anterior release	50375-50384	Hysteroscopy	35626-35636
dislocation, acetabulum fracture, treatment	47495,47498	Hysterotomy	35649
dislocation, congenital, treatment of	50349,50352		
dislocation, congenital, treatment of including paediatric	50650-50658	I	
dislocation, treatment of	47048,47051	Ileal atresia, neonatal, laparotomy for	43816
iliopsoas tendon transfer to greater trochanter	50387	Ileo-femoral by-pass grafting	32712,32718
prosthesis, operation on	49315	endarterectomy	33521
replacement procedures	49318-49345	Ileorectal anastomosis	32012
spica, application of	47540,50564	Ileostomy	32009-32021
spica, application, congenital dislocation	50353,50564	closure of, with rectal resection	32060,32063,32066
transfer of abdominal musculature to greater trochanter	50387	closure of, without resection of bowel	30562
transfer of adductors to ischium	50387	refashioning of	30563
treatment of including paediatric	50650-50658	reservoir, continent type, creation of	32069
Hirschsprung's disease, colostomy/enterostomy for	30375	trimming	*
disease, neonatal, laparotomy for	43819	with proctocolectomy	32015
disease, paediatric, operations for	43990-43999	with total colectomy	32009
Home, dialysis	13104	Iliac endarterectomy	33518
Hormone implantation, by cannula	14206	vein, thrombectomy	33810,33811
implantation, direct, incision and suture	14203	vessel, ligation or exploration not otherwise covered	34103
Humerus, bone graft to	48212,48215	Iliopsoas tendon transfer to greater trochanter	50387
fracture, treatment of	47411-47459	Immunisation against infectious disease	*
operation for osteomyelitis	43506,43515	Implanon, removal of	30062
osteotomy/osteotomy	48412,48415	Implant, cochlear, insertion of	41617
Hummelshheim type muscle transplant, squint	42848	epidural, for pain management, removal of	39136
Hydatid cyst, liver, total excision of	30437,30438	foreign, insertion for contour reconstruction	45051
cyst, liver, removal of contents of	30434,30436	insertion or removal from eye socket	42518
cyst, lungs, enucleation of	38424	Implantable Cardioverter Defibrillator	38384,38387,38371
Hydradenitis, excision for	31245	Implantable Cardioverter Defibrillator testing	11727
Hydrocele, infantile, repair of	30612,30614	implantable bone conduction hearing system	41603,41604
removal of	30631	Implantation, fallopian tubes into uterus	35694,35697
tapping of	30628	hormone or living tissue	14203,14206
Hydrocephalus, operations for	40000-40009	Impotence, injection for investigation/treatment	37415
Hydrocortisone, injections into keloid with GA	30210	Incidental appendectomy	30574
Hydrodilatation of bladder with cystoscopy	36827	Incisional hernia, repair of	30403
Hydromyelia, operations for	40339,40342	Incomplete confinement	16518
Hydrotubation of Fallopian tubes	35703,35709	Incontinence, anal, Parks' intersphincteric procedure	32126
Hymenectomy	35509	bladder stress, suprapubic operation	37044
Hyperbaric oxygen therapy	13020,13025,13030	male urinary, injection for treatment of	37339
Hyperemesis gravidarum, treatment of	16505	stress, sling operation for	35599
Hyperextension deformity of toe, release, lengthening	50345	Indirect flap	45227-45239
Hyperhidrosis, axillary, excision for	30180,30183	Induction, management, second trimester labour	16525
botulinum toxin injection, for	18362	Indwelling oesophageal tube, gastrostomy for fixation	30375
Hyperparathyroidism, operations for	30315-30320	Infantile hydrocele, repair of	30612,30614
Hyperplasia, papillary, of palate, removal of	45831-45835	Infection, acute intercurrent, complicating pregnancy	16508
Hypertelorism, correction, intra/sub-cranial	45767,45770	Inferior vena cava, thrombectomy	33810,33811
Hypertension, portal, treatment of	30602-30606	vena caval filter, insertion of	35330
Hypertrophied tissue, removal of	45801-45807	Infiltration, alcohol, etc, around nerve or in muscle	*
Hypnotherapy	*	of local anaesthetic	(see explan notes)
Hypodermic injections	*	Inflammation of middle ear, operation for	41626
Hypospadias, examination under GA	37815	Infliximab	14245
granuloplasty, meatal advancement	37818	Infusion chemotherapy	13915-13936
meatotomy and hemi-circumcision	37354	chemotherapy, cannulation for	34521,34524
penis erection test with examination	37815	device, automated, spinal, insertion of	39125-39128
repair of	37821-37833	intra-arterial, sympatholytic agent	14209
urethral fistula repair	37833	Ingrowing eyelashes, operation for	45626
Hypothenar spaces of hand, drainage of	46519	nail of finger or thumb, resection of	46528,46531
Hypothermia, gastric	13500,13503	nail of toe, resection of	47915,47916
deep hypothermic circulatory arrest	22075	Inguinal abscess, incision of	30223
total body	22065	hernia, repair of	30609,30612,30614
Hysterectomy	35653-35673		

* Payable on attendance basis

Service	Item	Service	Item
hernia, repair, age less than 3 months	44108,44111,44114	foreign body, removal of	42560-42569
Injection, alcohol, etc, around nerve or in muscle	*	procedures, resuturing of wound after	42857
alcohol, cortisone, phenol into trigeminal nerve	39100	Intra-operative ultrasound, biliary tract	30439
alcohol, retrobulbar	42824	staging of intra-abdominal tumours	30441
hormones, for habitual miscarriage	16504	Intra-oral tumour, radical excision of	30275
immunoglobulin	*	Intra-orbital abscess, drainage of	42572
into angioma (restriction applies)	45027	Intracerebral tumour, craniotomy and removal of	39709
into joint/synovial cavity	50124,50125	Intracranial abscess, excision of	39903
into prostate	37218	aneurysm, clipping or reinforcement of sac	39800
into spinal joints or nerves	39013	aneurysm, endovascular coiling	35412
intramuscular	*	aneurysm, ligation of cervical vessel/s	39812
intravenous	*	arteriovenous malformation, excision of	39803
local anaesthetic	(see explan notes)	cyst, drainage of via burr-hole	39703
sclerosant fluid into pilonidal sinus	30679	electrode placement	40709,40712
Injections, multiple, for skin lesions	30207	haemorrhage, burr-hole craniotomy for	39600,39603
varicose veins	*	infection, drainage of via burr-hole	39900
Inlay graft, using a mould	45445	neurectomy, for trigeminal neuralgia	39106
Innocent bone tumour, excision of	30241	pressure monitoring device, insertion of	39015
Innominate artery, endarterectomy of	33506	pressure monitoring, catheter/subarachnoid bolt	13830
Inoculation against infectious disease	*	stereotactic procedures	40800,40803
Insufflation Fallopian tubes, for patency (Rubin test)	35706	tumour, biopsy and/or decompression	39706
Intensive care management/procedures	13815-13888	tumour, burr-hole biopsy for	39703,39706
Intercostal drain, insertion of	38806,38809	tumour, craniotomy and removal of	39709,39712
Internal auditory meatus, exploration of	41599	Intradiscal injection of chymopapain	40336
drainage of empyema, without rib resection	38806,38809	Intradural lesion, laminectomy for, not otherwise covered	40312
Interosseous muscle space of hand, fasciotomy of	47981	Intrahepatic bypass	30466,30467
Interphalangeal joint, arthrodesis of	46300	Intramedullary tumour, laminectomy and radical excision	40318
joint, arthrotomy of	46327,46330	Intramuscular injections	*
joint, dislocation, treatment of	47036,47039	Intranasal operation on antrum/removal of foreign body	41716
joint, hemiarthroplasty	46309-46321	operation on frontal sinus or ethmoid sinuses	41737
joint, interposition arthroplasty of	46306	operation on sphenoidal sinus	41752
joint, joint capsule release of	46381	Intrascleral ball or cartilage, insertion of	42515
joint, ligamentous repair	46333	Intrathecal infusion device, revision of	39133
joint, synovectomy/capsulectomy/debridement	46336	infusion/injection	(see Group T7)
joint, total replacement arthroplasty of	46309-46321	steroid injection	18232
joint, volar plate arthroplasty	46307	Intrathoracic operation on heart, lungs, etc, other	38456
Interscapulothoracic amputation or disarticulation	44334	vessels, anastomosis/repair	38727,38730
Interventional endovascular procedures	35300-35330	Intrauterine contraceptive device, introduction of	35503
Intervertebral disc/s, laminectomy for removal of	40300	contraceptive device, removal of under GA	35506
disc, lumbar, total artificial replacement	48691,48692,48693	device, introduction of, for idiopathic menorrhagia	35502
disc/s, microsurgical discectomy of	40301	growth retardation, attendance for	16508
Intestinal conduit or reservoir, endoscopic examination	36860	Intravascular injections	*
duct, patent vitello, excision of	43945	brachytherapy, for coronary artery restenoses	15360,15363,15541
malrotation, neonatal, laparotomy for	43801,43804	pressure monitoring	13876
obstruction, surgical relief of	30387	Intravenous infusion chemotherapy	13915-13924
plication, Noble type, with enterolysis	30375	injections	*
remnant, abdominal wall vitello, excision of	43942	perfusion of a sympatholytic agent	14209
resection, large	32000,32003	regional anaesthesia of limb	18213
resection, small	30565,30566	Intraventricular baffle, insertion of	38754
sling procedure prior to radiotherapy	32183	Intubation, small bowel	30487,30488
urinary conduit, revision	36609	Intussusception, reduction of	30375
urinary reservoir, continent, formation	36606	management fluid/gas reduction for	14212
Intra-abdominal artery/vein, cannulation, chemotherapy	34521	paediatric, operations for	43933,43936
malignancy, radical or debulking operation	30392	Invitro fertilisation	13200-13221
Intra-anal abscess, drainage of	32174,32175	processing of bone marrow	13760
Intra-aortic balloon, counterpulsation, management	13848,13847	Ionisation, cervix	35608
balloon pump, insertion of	38609,38362	corneal ulcer	*
balloon pump, removal of	38612,38613	zinc, of nostrils, in the treatment of hay fever	*
Intra-arterial cannulisation for blood collection	13842	Iontophoresis, collection of specimen of sweat by	12200
infusion chemotherapy	13927-13936	Iridectomy	42764
infusion, of sympatholytic agent	14209	and sclerectomy, for glaucoma (Lagrange's op)	42746
Intra-atrial baffle, insertion of	38745	following intraocular procedures	42857
Intra-epithelial neoplasia, laser therapy for	35539,35542,35545	Iridenclieisis	42746
Intra-ocular excision of dermoid of eye	42574	Iridocyclectomy	42767

* Payable on attendance basis

Service	Item	Service	Item
division of adhesions	30393,35637	trabeculectomy	42782,42783
involving procedures via laparoscope	35637,35638	treatment, eye	42782-42806
laparoscopically assisted hysterectomy	35750-35756	vitrectomy/corticectomy	42791,42792
on abdominal viscera	30375	Lateral pharyngeal bands, removal of	41804
sterilisation via	35687,35688	pharyngotomy	41779
with biopsy	30391	rhinotomy with removal of tumour	41728
with drainage of pus	31454	Lavage and proof puncture of maxillary antrum	41698,41701
with transection/resection Fallopian tubes	35687,35688	colonic, total, intra-operative	32186
Laparostomy	30397,30399	colostomy	*
Laparotomy and division of adhesions	30376,30378,30379	gastric, in the treatment of ingested poison	14200
exploratory	30373	maxillary antrum	41704
for control of post-operative haemorrhage	30385,33845	stomach	*
for drainage	30394	uterine (saline flushing)	*
for grading of lymphoma	30384	Le Fort osteotomies	45753,45754
for gross intra-peritoneal sepsis	30396	operation for genital prolapse	35578
for intussusception, paediatric	43933,43936	Leg, amputation	44367,44370
for neonatal conditions	43801-43831	hamstring tendon transfer	50357,50360
for staging of gynaecological malignancy	35726	rectus femoris tendon transfer	50357
for thrombosis	33845	Lens, artificial, insertion of	42701,42703
for trauma, involving 3 or more organs	30388	artificial, removal and replacement	42707,42710
involving gynaecology (exc. hysterectomy)	35712-35717	artificial, removal or repositioning	42704
on abdominal viscera	30375,30387	extraction	42698
with division of extensive adhesions	30379	extraction and insertion of artificial lens	42702
with insertion of portacath	30400	intraocular, repositioning of	42713
Large intestine, resection of	32000,32003	Lensectomy	42731
intestine, subtotal colectomy	32004,32005	Lesion, craniocervical junction, transoral approach for	40315
Laryngeal web, division of	41868	intradural, laminectomy for, not otherwise covered	40312
Laryngectomy	41834	Lesions, skin, multiple injections for	30207
supraglottic	41840	Leukoplakia, tongue, diathermy for	*
Laryngofissure, external operation on	41876	Leveen shunt, insertion of	30408
Laryngopharyngectomy	41843	Lid, ophthalmic, suturing of	42584
- or primary restoration of alimentary continuity after	41843	scleral graft to	42860
- with tracheostomy and plastic reconstruction	30294	Ligament, finger joint, repair of	46333
Laryngoplasty	41876,41879	of foot, repair of	49812
Laryngoscopy	41846,41849,41852	or tendon transfer	47966
fibreoptic, with examination of larynx	41764	ruptured medial palpebral, repair of	42854
Larynx, direct examination of	41846	transplantation	47966
direct examination of, with biopsy	41849	Ligation, great vessel	34103
direct examination of, with removal of tumour	41852	purse string, cervix	16511
external operation on	41876	rubber band, of haemorrhoids or rectal prolapse	32135
fibreoptic examination of	41764	transantral, of maxillary artery	41707
fractured, operation for	41873	Ligature of cervix, purse string, removal of	16512
Laser: ablation of prostate, endoscopic	37207,37208	Limb, fasciotomy of	30226
Doppler interferometry of eyes	11240-11243	Limb, amputation	(see leg/arm)
angioplasty, peripheral	35315	ischaemic, debridement of tissue	35100,35103
capsulotomy	42788,42789	lengthening procedures	50303,50306
coagulation corneal/scleral vessels	42797	lower, congenital deficiency, treatment of	50411,50414,50417
destruction of bladder tumour with cystoscopy	36845,36840	or chest, decompression escharotomy	45054
destruction of stone with urethroscopy	37318	perfusion of	34533,22055
diathermy/visual laser for lesion of prostate	37224-37224	Limbic tumour, removal or excision of	42692,42695
division of suture, eye	42794	Linea alba hernia, repair of, under 10 years	30616,30617
excision, tumours of face/neck	30190	alba hernia, repair of, over 10 years	30620,30621
incision of palate	41787	Lingual tonsil, removal of	41804
iridotomy	42785,42786	Lip, cleft, operations for	45677-45704
photocoagulation of iris tumour	42806	full thickness laceration, repair	30052
photocoagulation of neoplastic skin lesions	30195	full thickness wedge excision	45665
photocoagulation of vascular lesions	14100-14124	reconstruction	45671,45674
photoiridosyneresis	42808	tumour, excision of	(see tumour, other)
photomydriasis	42807	Lipectomy, radical abdominoplasty	30177
removal of cancer of skin/mucous membrane	30196	subumbilical excision	30174
removal of palmar/plantar warts	30187	wedge excision	30165,30168,30171
resurfacing, carbon dioxide, face or neck	45025,45026	Lipoma, removal of	(see tumour, other)
therapy for intraepithelial neoplasia	35539,35542,35545	Lipomeningocele, tethered cord, release of	40112
therapy for malignancy of gastrointestinal tract	30479	Liposuction, for post-traumatic pseudolipoma	45584,45585

* Payable on attendance basis

Service	Item	Service	Item
abdominal contouring post diabetic injections	31346	granulomatous disease	44130
for reduction of a buffalo hump	45586	pelvic	35551,36502
free tissue transfer, complete revision of	45497	Lymphangiectasis, limbs, major excision	45048
free tissue transfer, first stage revision of	45498	Lymphangioma, excision of	45030-45036
free tissue transfer, second stage revision	45499	Lymphoedema, major excision of	45048
Lippe's loop, introduction of	35503	Lymphoid patches, removal of	45801-45809
loop, removal of under GA	35506		
Lisfranc's amputation	44364	M	
Litholapaxy, with or without cystoscopy	36863	Macrocheilia, operation for	45675
Lithotripsy, extracorporeal shock wave (ESWL)	36546	Macroductyly, surgical reduction of enlarged elements	46510
Little's Area, cautery of	41674	Macroglossia, operation for	45675
Liver abscess, open abdominal drainage of	30431,30433	Macrostomia, operation for	45676
biopsy	30409,30411,30412	Macules, electrosurgical destruction or chemotherapy of	*
cyst/s, laparoscopic marsupialisation	30416,30417	Magnetic removal of intraocular foreign body	42560,42566
hydatid cyst, removal of contents of	30434,30436	Malignant lesion, removal of	31300-31335
hydatid cyst, total excision of	30437,30438	Malignant upper aerodigestive tract tumour	31400,31403,31406
lobectomy of, for trauma	30428,30430	excision of	
lobectomy of, other than for trauma	30418,30421	Mallet finger, closed pin fixation of	46438
repair of laceration/s, for trauma	30422,30425	finger, open repair of text test	46441
ruptured, repair	30375	finger, with intra-articular fracture, open reduction	46442
segmental resection of	30414,30415,30427	Mammoplasty, augmentation	45524,45527,45528
tumours destruction by radiofrequency ablation	50950,50952	reduction	45520,45522
tumours, destruction of by cryotherapy	30419	Mammary prosthesis, removal of	45548,45551,45552
Living tissue, implantation of	14203,14206	prosthesis, replacement of	45552,45554,45553
Lobar emphysema, neonatal, thoracotomy & lung resection	43861	Manchester operation for genital prolapse	35577
Lobectomy, liver, for trauma	30428,30430	Mandible, condylectomy	45611
liver, other than for trauma	30418,30421	dislocations, treatment of	47000
lung	38438,38441	hemi-mandibular reconstruction with bone graft	45608
partial, for epilepsy	40703	operation on, for acute osteomyelitis	43503
superficial, of parotid gland	30253	operation on, for chronic osteomyelitis	43512,45815
Local anaesthetic, injection of	(see explan notes)	or maxilla, fractures, treatment of	47753-47789
flap repair	45200,45203,45206	osteectomy or osteotomy of	45720-45752
flap revision	45239,45240	resection of	45599,45602,45605
infiltration, nerve/muscle, with alcohol etc.	*	segmental resection of, for tumours	45605
Loose bodies in joint	(see arthrotoomy)	Mandibular, frenulum, repair of, under GA	30281
Lop ear or similar deformity, correction of	45659	or palatal exostosis, excision of	45825
Lord's procedure, massive dilatation of anus	32153	Manipulation of fibrous tissue surrounding breast prosthesis	*
Lumbar cerebrospinal fluid drain, insertion of	40018	of joints	50115
decompression of spinal cord	40351	of spine	48600,48603
discectomy, percutaneous	48636	of ureteric calculus, endoscopic	36857
puncture	39000	without anaesthesia	*
shunt diversion, insertion of	40006	Manometric oesophageal motility test	11800
shunt, revision or removal of	40009	Manometry, biliary	30493
sympathectomy	35000,35009	Marshall-Marchetti operation for urethropexy	35599,37044
Lunate bone, osteectomy or osteotomy of	48406	Marsupialisation of Bartholin's cyst or gland	35516,35517
Lung compliance, estimation of	11503	salivary gland	30265,30266
hydatid cysts, enucleation of	38424	Mastectomy, total	31518,31521
intrathoracic operation, not otherwise covered	38456	subcutaneous	31524,31527
needle biopsy of	38812	Mastitis, granulomatous, exploration and drainage	31551
resection, congenital cystadenomatoid malformation	43861	Mastoid cavity, obliteration of	41548,41564
resection, congenital lobar emphysema	43861	portion, decompression of facial nerve	41569
volumes	11503	Mastoidectomy, cortical	41545
wedge resection of	38440	intact wall technique, with myringoplasty	41551,41554
Lymph glands, axilla, excision of	30332,30335,30336	radical or modified radical	41557-41564
glands, biopsy of	30074,30075,30078	revision of, with myringoplasty	41566
glands, groin, excision of	30329,30330	with insertion of cochlear implant	41617
glands, pelvic, radical excision of	35551	with transmastoid removal of glomus tumour	41623
node biopsies, retroperitoneal	35723	Maxilla, operation on, for acute osteomyelitis	43503
node dissection, retroperitoneal	37607,37610	operation on, for chronic osteomyelitis	43512,45815
node of neck, biopsy of	31420	or mandible, fractures, treatment of	47753-47789
nodes of axilla, excision of	30335,30336	osteectomy or osteotomy	45720-45752
nodes of neck, dissection of	31423-31438	resection of, segmental, for tumour/cyst	45605
sentinel node biopsy for breast cancer	30299-30303	resection of, sub-total	45602
Lymphadenectomy, atypical mycobacterial infection	44130		

* Payable on attendance basis

Service	Item	Service	Item
resection of, total	45596,45597	- with removal of juvenile papillomata	41858
Maxillary antrum, lavage of	41704	- with removal of papillomata by laser surgery	41861
antrum, proof puncture and lavage of	41698,41701	- with removal of tumour	41864
artery, transantral ligation of	41707	Microsomia, construction of condyle and ramus	45791
frenulum, repair of	30281	Microvascular anastomosis using microsurgical techniques	45502
sinus lift procedure	45849	for supercharging of pedicled flaps	45561
sinus, drainage of, through tooth socket	41719	repair using microsurgical techniques	45500,45501,45504
sinus, operations on	41710-41722	Microvenous graft	45503
tuberosity, reduction of	45829	Middle ear, clearance of	41635,41638
Meatoplasty, with correction of auditory canal stenosis	41521	ear, exploration of	41629
with removal of cartilage and/or bone	41512,41515	ear, insertion of tube for drainage of	41632
Meatotomy and hemi-circumcision, hypospadias	37354	ear, operation for abscess or inflammation of	41626
ureteric, with cystoscopy	30265,30266,36830	palmar spaces of hand, drainage of	46519
urethral	37321	Midtarsal amputation of foot	44364
Meatus, external auditory, removal of exostoses in	41518	Miles' operation	32039
external auditory, removal of keratosis obturans	41509	Minitracheostomy insertion	41884
internal auditory, exploration of	41599	Minnesota tube, insertion of	13506
pinhole urinary, dilatation of	37300	Miscarriage, habitual, treatment of	16504
Meckel's diverticulum, removal of	30375	incomplete, curettage for	35639,35640
Meconium ileus, laparotomy for	43813,43816	threatened, ligation of cervix	16511
Medial palpebral ligament, ruptured, repair of	42854	threatened, treatment of	16505
Median bar, endoscopic resection of	36854	Mitral annulus, reconstruction after decalcification	38485
sternotomy for post-operative bleeding	38656	valve, open valvotomy of	38487
Mediastinum, cervical exploration of	38448	Mitrofanoff continent valve, formation of	37045
exploration of, for hyperparathyroidism	30318,30320	Moh's procedure	31000,31001,31002
intrathoracic operation on, not otherwise covered	38456	Mole, desiccation by diathermy	*
Meibomian cyst, extirpation of	42575	retained, evacuation of	16564
Melanoma, removal of	31300-31335	Molluscum contagiosum, removal in operating theatre	30189
excision of, oral & maxillofacial region	45801-45809	Morbid obesity, operations for	30511,30512,30514
Melasma, full face chemical peel	45019,45020	Moschowitz operation	35590
Meloplasty, for correction of facial asymmetry	45587,45588	Motility test, manometric, of oesophagus	11800
Membranes, retained, evacuation of	16564	Mouth, premalignant growth in, removal of	(see tumour,other)
Meningeal haemorrhage, operations for	39600,39603	Mucous membrane, biopsy of	30071
Meningocele, excision and closure of	40100	membrane, cancer, treatment	30196-30205
Menisectomy, knee	49503,49506	membrane, graft	42641
temporo-mandibular	45755	membrane, repair of recent wound	30026-30049
Mesenteric artery, inferior, operation on	32736	Multiple delivery, administration of anaesthetic	
vessels, by-pass grafting to	32730,32733	Multiple, injections for varicose veins	32500,32501
Meso caval shunt for portal hypertension	30603	pregnancy, interventional techniques	16633,16636
Metacarpal bones, amputation of	44325	Muscle, activity sampling (electromyography)	11012,11015,11018
bones, bone grafting, pseudarthrosis	46402,46405	biopsy of	30074,30075
bones, fracture, treatment of	47336-47345	distal, devascularisation of	32200
bones, operation for osteomyelitis	46462	excision of	30226,30229
bones, osteotomy/osteectomy	46396,46399	excision of, with melanoma	31340
Metacarpophalangeal joint, arthrodesis	46300	extra-ocular, ruptured, repair of	42854
joint, arthroplasty	46306-46321	flap repair	45000,45009,45012
joint, arthrotomy	46327,46330	flap, delay of	45015
joint, dislocation, treatment of	47042,47045	local infiltration in	*
joint, hemiarthroplasty	46309-46321	removal of foreign body from	30067,30068
joint, ligamentous repair of	46333	ruptured, repair of	30232,30235
joint, volar plate arthroplasty	46307	transfer for facial nerve paralysis	45578
Metacarpus, operation on, for chronic osteomyelitis	43512	transplant (Hummelsheim type), for squint	42848
Metastatic carcinoma, craniotomy for removal of	39709	Myelomeningocele, excision and closure of	40103
Metatarsal bones, osteotomy or osteectomy of	48400,48403	Myelotomy, laminectomy for	39124
fracture, treatment of	47633-47657	Mylohyloid ridge, reduction of	45827
Metatarso-phalangeal joint, synovectomy of	49860,49863	Myocardial electrode, permanent, insertion, thoracotomy	38470
joint, total replacement of	49857	biopsy, by cardiac catheterisation	38275
Metatarsus, amputation or disarticulation of	44358	Myocutaneous flap, delay of	45015
operation on, for acute osteomyelitis	43500	flap repair	45003,45006
Micro-arterial graft	45503	Myoma, hysteroscopic resection	35623
Microdochotomy of breast, benign or malignant condition	31554	Myomectomy, hypertrophic obstructive cardiomyopathy	38650
Microlaryngoscopy	41855	uterine, abdominal	35649
- with arytenoidectomy	41867	uterine, laparoscopic	35638
- with division of laryngeal web	41868	Myotomy, cricopharyngeal	41770,41776

* Payable on attendance basis

Service	Item	Service	Item
coherence biometry/tomography	11240-11243	Oro-antral fistula, plastic closure of	41722
surface dysplasia, investigation	11235	pin or wire, insertion of	47921
transillumination	42821	Oro-nasal fistula, plastic closure of	45714
Oculoplethysmography, carotid vessels	11618,11621,11624	Orthopaedic pin or wire, insertion of	47921
Odontoid screw fixation	40316	ring fixator, adjustment of	50309
Oesophageal atresia, neonatal, operations for	43843-43858	Osseo-integration procedures	45794,45797,45847
atresia/corrosive stricture, replacement for	43903	for implantable bone conduction hearing system	41603,41604
motility test, manometric	11800	Ossicular chain reconstruction	41539,41542
perforation, repair of, by thoracotomy	30560	Osteectomy of accessory bone	48400
prosthesis, insertion of	30490	carpus	48406,48409
stricture, endoscopic dilatation of	41819,41820	clavicle	48406,48409
transection for portal hypertension	30606	femur	48424,48427
tube, indwelling, gastrostomy for fixation	30375	fibula	48406,48409
Oesophagectomy	30535-30557	humerus	48412,48415
cervical	30294	mandible or maxilla	45720-45752
Oesophagogastric myotomy	30532,30533	metatarsal	48400,48403
Oesophagoscopy	30473-30478	pelvic bone	48424
with dilatation of stricture	41819,41820	pelvis	48427
with rigid oesophagoscope	41816,41822,41825	phalanx	48400,48403
Oesophagostomy, cervical	30293,30294	radius	48406
cervical, neonatal oesophageal atresia	43858	rib	48406
closure or plastic repair of	30293	scapula (other than acromion)	48406
Oesophagus, resection of stricture, paediatric	43906	sesamoid bone	48400
balloon dilatation of	41832	tarsus	48406
dilatation of	41819-41831	tibia	48418,48421
intrathoracic operation on, not otherwise covered	38456	ulna	48406
local excision for tumour	30559	Osteomyelitis, acute or chronic, operations for	43500-43524
removal of foreign body in	41825	carpus, operation for	46462
Olecranon, excision of bursa of	30110,30111	metacarpal, operation for	46462
fracture, treatment of	47396,47399,47402	operations for, in oral and maxillofacial region	45815,45817
fracture, treatment of paediatric	50540	phalanx, operation for	46459,46462
Omentectomy, infra-colic	35726	skull, craniectomy for	39906
with debulking operation	35720	Osteoplasty of knee	49503,49506
Oophorectomy, laparoscopic	35638	Osteotomy of accessory bone	48400
with laparotomy, not with hysterectomy	35712-35717	carpus	48406,48409
with vaginal hysterectomy	35673	clavicle	48406,48409
Open heart surgery, not otherwise covered	38653	femur	48424,48427
Operative arteriography or venography	35200	fibula	48406,48409
cholangiography or pancreatography	30439	foot	49833-49838
feeding jejunostomy	31462	humerus	48412,48415
laparoscopy, complicated	35641	mandible or maxilla	45720-45752
Ophthalmological examination under GA	42503	metatarsal	48400,48403
Optic fundi, examination of	11212	midfacial	45753,45754
nerve meninges, incision of	42548	pelvic bone	48424
Optical coherence biometry/tomography	11240-11243	pelvis	48427
Orbit, anophthalmic, insertion of cartilage or implant	42518	phalanx	48400,48403
anophthalmic, placement of motility integrating peg	42518	radius	48406,48409
eye, decompression of	42545	rib	48406,48409
eye, exenteration of	42536	scapula (other than acromion)	48406,48409
eye, exploration of	42530,42533	sesamoid bone	48400
eye, removal tumour/foreign body	42539,42542,42543	tarsus	48406,48409
eye, skin graft to	42524	tibia	48418,48421
Orbital cavity, bone or cartilage graft to	45593	ulna	48406,48409
cavity, reconstruction of	45590	Otitis media, acute, operation for	41626
contents, partial coherence interferometry of	11240-11243	Oto-acoustic emission audiometry	11332
contents, ultrasonic echography of	11240,11241,11242	Oval window surgery	41615
11243		Ovarian biopsy by laparoscopy	35637
dermoid, congenital, excision of	42574	cyst aspiration	35518
dystopia, correction of	45776,45779	cyst, excision of, with hysterectomy	35673
implant, enucleation of eye	42506,42509	cyst, excision of, with laparotomy	35712-35717
implant, evisceration of eye and insertion of	42515	cyst, puncture of, via laparoscope	35637
Orbitotomy	42530,42533	cystectomy, laparoscopic	35638
Orchidectomy	30638,30641	transposition with hysterectomy for malignancy	35729
Orchidopexy for undescended testis	37803,37806,37809	tumour, radical or debulking operation for	35720

* Payable on attendance basis

Service	Item	Service	Item
Ovaries, prolapse, operation for	30387	removal of tunnelled cuffed catheter	34539
Oxycephaly, cranial vault reconstruction for	45785	Paretic states, eyebrows, elevation of	42872
Oxygen consumption, estimation of	11503	Parks' intersphincteric operation	32126
therapy, hyperbaric	13020,13025,13030	Paronychia of foot, incision for	47912
ovaries, operation for	30387-30387	of hand, incision for	46525
rectum, abdominal rectopexy	32117	Parotid duct, diathermy or dilatation	30262
rectum, perineal repair of	32120	duct, meatotomy or marsupialisation	30265,30266
rectum, reduction of	*	duct, removal of calculus	30265,30266
rectum, rubber band ligation of	32135	duct, repair of,	30246
rectum, sclerotherapy for	32132	fistula, repair of	30269
urethra	35570,35573	gland, superficial lobectomy/removal of tumour	30253
urethra, excision of	37369	gland, total extirpation of	30247,30250
vaginal, repair of	35568-35597	tumour, excision of	30251
P			
Pacemaker electrode, permanent, insertion, sub-xyphoid	38473	grafting to artery or vein	33545,33548
gracilis neosphincter	32210	testing, epicutaneous	12012-12021
implanted, testing of	11718,11721	Patella, bursa, excision of	30110,30111
permanent, insertion or replacement	38353	congenital dislocation, reconstruction of quadriceps	50420
Pacemaking electrode, temporary transvenous, insertion	38256	dislocation, treatment of	47057,47060
Pain management, implanted drug delivery system	39125-39133	fracture, treatment of	47579,47582,47585
spinal and peripheral nerve stimulation	39130-39139	Patellar bursa, excision of	30110,30111
Palatal exostosis, excision of	45825	Patellectomy	49503,49506
Palate, cleft, repair of	45707,45710,45713	Patello-femoral stabilisation	49503,49506,49564
papillary hyperplasia removal of	52609-52615	stabilisation, revision of	49548
Palmar warts, removal of	30186,30187,30185	Patent diseased coronary bypass vein graft, dissection	38637
Palpebral ligament, medial, ruptured, repair of	42854	ductus arteriosus, division/ligation	38700,38703
lobe of lacrimal gland, excision of	42593	urachus, excision of	37800
Pancreas, drainage of	30375	Pectus carinatum, repair or radical correction	38457
excision of	30583	excavatum, repair or radical correction	38457,38458
Pancreatectomy	30583,30593,30594	Pedicle, tubed, or indirect flap	45230
Pancreatic abscess, laparotomy and external drainage of	30575	- delay of	
cyst, anastomosis to Roux loop of jejunum	30587	- formation of	45227
cyst, anastomosis to stomach or duodenum	30586	- preparation of site and attachment to site	45233
juice, collection of	30488	- spreading of pedicle	45236
necrosectomy	30577	Pelvi-ureteric junction, plastic procedures to	36564
Pancreatico-duodenectomy (Whipple's operation)	30584	cystoscopy of	36825
Pancreatico-jejunostomy	30589,30590	Pelvic abscess, drainage via rectum or vagina	30223
Pancreato-cholangiography, endoscopic	30484	abscess, laparotomy for drainage of	30394
Pancreatography, operative	30439	bone, operation on, for osteomyelitis	43509,43518
Panendoscopy	30473,30476,30478	bone, osteectomy or osteotomy of	48424,48427
Panhysterectomy	35664	floor abnormalities, diagnosis of	11830,11833
Pannus, treatment of, with cautery of conjunctiva	42677	floor repair, laparoscopic or abdominal	35595
Papilloma, bladder, transurethral resection	36845,36840	haematoma, drainage of	30387
larynx, removal of	41852	lymph glands, excision of	35551,35664,35670
removal in oral & maxillofacial region	45801-45809	ring, fracture, treatment of	47474-47489
removal of	(see tumour,other)	Pelvic lymphadenectomy	36502
Papillomata, juvenile, removal with microlaryngoscopy	41858	Pelvis, bone graft/shelf procedure, acetabular dysplasia	50393
removal of by laser surgery	41861	fracture, treatment of	47474-47510
Papules, electrosurgical destruction or chemotherapy of	*	osteotomy or osteectomy of	48424,48427
Para-oesophageal, hiatus hernia, repair of	31468	Penicillin, injection of	*
Paracentesis abdominis	30406	Penile warts, cystoscopy for treatment of	36815
anterior or posterior chamber or both	42740	Penis, amputation of	37402,37405
in relation to eye	42734	artificial erection device, insertion	37426,37429
of pericardium	38406	artificial erection device, revision or removal of	37432
of tympanum	41626	circumcision of	30653-30660
thoracic cavity	38803	correction of chordee	37417,37418
Paralysis, facial nerve, plastic operations for	45575,45578	frenuloplasty	37435
Parapharyngeal tumour, excision of	31409,31412	injection for impotence	37415
Paraphimosis, reduction of under GA	30666	lengthening by translocation of corpora	37423
Parathyroid operation for hyperparathyroidism	30315	paraphimosis, reduction of under GA	30666
Parental nutrition		partial amputation of	37402
central vein, tunnelled cuffed catheter	34538	repair of avulsion	37411

* Payable on attendance basis

Service	Item	Service	Item
repair of laceration of cavernous tissue, or fracture surgery for penile drainage causing impotence	37408 37420	Peripheral arterial atherectomy	35312
Peptic ulcer, bleeding, control of	30505-30509	arterial catheterisation	35321
ulcer, perforated, suture of	30375	cannulation for cardiopulmonary bypass	38603
Per anal release, rectal stricture	32114	laser angioplasty	35315
Perchlorate discharge study	12521	nerve, neurectomy/neurotomy/tumour	39324,39327
Percutaneous aspiration biopsy of deep organ	30094	peripheral nerve stimulation for pain	39131-39137
biliary dilatation	30495	venous catheterisation	35317,35319,35320
biliary drainage	30440,30451,30495	vessels, examination of	11603-11612
biliary stenting	30492	Peritomy, conjunctival	42632
cordotomy	39121	Peritoneal adhesions, division, with laparotomy	30376,30378,30379
drainage of deep abscess, imaging guided	30224	biopsies, multiple, with infracolic omentectomy	35726
endoscopic gastrostomy	30481,30482	catheter, insertion and fixation of	13109
epidural electrode, insertion	39130	catheter, removal of	13110
epidural electrodes, management of	39131	dialysis	13112
epidural implant, removal	39136	Peritoneo venous (Leveen) shunt, insertion of	30408
gastrostomy tube, jejunal extension	31460	Peritoneoscopy	(see laparoscopy)
liver biopsy	30409	Peritonitis, laparotomy for	30394
lumbar discectomy	48636	Peritonsillar abscess, incision of	41807
needle biopsy of lung	38812	Periurethral injection for urinary incontinence	37339
neurotomy for facet joint denervation	39118	Perthes, hips or knees, application of cast under GA	50390
neurotomy of peripheral nerves	39323	Petro-clival and clival tumour, removal of	39653,39654,39656
neurotomy of spinal nerves	39115	Peyronie's plaque, operation for	37417
retrieval of foreign body	35360-35363	Phalanges, amputation/splitting, congenital abnormalities	50396
retrieval of inferior vena caval filter	35331	Phalanx, bone grafting of, for pseudarthrosis	46402,46405
transhepatic cholangiogram, imaging guided	30440	distal, for osteomyelitis	46459
ureteric stent exchange	36608	finger or thumb, fractures, treatment of	47300-47333
Perforated duodenal ulcer, suture of	30375	middle or proximal, for osteomyelitis	46462
gastric ulcer, suture of	30375	operation for acute osteomyelitis	43500
peptic ulcer, suture of	30375	operation for chronic osteomyelitis	43512
Perforating wound of eyeball, repair of	42551,42554,42557	osteectomy or osteotomy of	46399,48400,48403
Perfusion of donor kidney, continuous	22055	toe, fracture, treatment of	47663-47678
of limb or organ	22055	Pharyngeal adhesions, division of	41758
retrograde, cerebral (if performed)	22075	bands or lingual tonsils, removal of	41804
retrograde, intravenous, sympatheolytic agent	14209	cysts, removal of	41813
whole body	22060	flap for velo-pharyngeal incompetence	45716
Perianal abscess, drainage of	32174,32175	pouch, endoscopic resection (Dohlman's op)	41773
abscess, incision with drainage	30223	pouch, removal of	41770
excision of rectal tumour	32103,32104,32106	Pharyngectomy, partial	41782,41785
tag, removal of, without GA	*	Pharyngoplasty	45716
thrombosis, incision of	32147	Pharyngotomy (lateral)	41779
Pericardectomy	38447,38449	Pharynx, cauterisation or diathermy	41674
Pericardium, drainage of, sub-xyphoid	38452	removal of foreign body from	30061
drainage of, transthoracic	38450	Phlebotomy	*
paracentesis of	38406	Phonoangiography, carotid vessels	11618,11621,11624
Perimetry, quantitative	*	Photocoagulation, laser, vascular lesions	14100-14124
quantitative, computerised	11221-11225	of xenon arc	42782,42783
Perineal anoplasty, ano-rectal malformation	43960	Photoiridosyneresis, laser	42808
biopsy of prostate	37212	Photomydriasis, laser	42807
graciloplasty	32203,32209	Phototherapeutic, keratectomy	42810
graciloplasty, insert. stimulator & electrode	32209	Physician, consultant, attendance by	(see attendances)
prostatectomy	37200	Pigeon chest, correction of	38457
recto-sigmoidectomy for rectal prolapse	32112	Pilonidal cyst or sinus, excision of	30675,30676
repair of rectocele	32131	sinus, injection of sclerosant fluid	30679
repair, rectal prolapse	32120	Pin, orthopaedic, insertion of	47921
stimulation maximal, electrical	*	wire or screw, buried, removal of	47924,47927
stimulation maximal, for stress incontinence	*	Pinealoma, craniotomy for removal of	39712
Perineorrhaphy	35571	Pinguecula, removal of	42689
and anterior colporrhaphy	35580	Pinhole urinary meatus, dilatation of	37300
Perinephric abscess, drainage of	36537	Pirogoff's amputation of foot	44361
area, exploration of	36537	Pitanguy abdominoplasty	30177
Periorbital correction of Treacher Collins Syndrome	45773	Pituitary tumour, removal of	39715
Doppler examination, carotid vessels	11618,11621,11624	Placement of catheters	38220,38222,38243
dermoid, congenital, excision of	42573	Placement of catheters and injection of opaque material	
		Placenta, retained, evacuation of	16564

* Payable on attendance basis

Service	Item	Service	Item
ultrasonic localisation by Doppler	*	Premature labour, attendances not routine antenatal	16502,16508
Placentography, preparation for	36800	Prepuce, breakdown of adhesions of operations on	* 30653-30666
Plantar fasciotomy, radical	49854	Presacral and sacrococcygeal tumour, excision of	32036
warts, removal of	30186,30187	sympathectomy	35012
Plaster jacket, application of, to spine	47708	Pressure monitoring, intracranial	13830
Plastic procedures to pelvi-ureteric junction	36564	monitoring, intravascular	13876
reconstruction for bicornuate uterus	35680	Priapism, decompression of	37393
reconstruction of lacrimal canaliculus	42602	shunt operation for	37396
repair, direct flap	45209-45224	Primary repair of cutaneous nerve	39300
repair, of cervical oesophagostomy	30293	repair of extensor tendon of hand or wrist	46420
repair, single stage, local flap	45200,45203,45206	repair of flexor tendon of hand or wrist	46426,46432
repair, to enlarge vaginal orifice	35569	repair of nerve trunk	39306
Plate, rod or nail, removal of	47930	restoration of alimentary continuity	41843
Plethysmography	11604-11612	Proctectomy, perineal	32047
Pleura, percutaneous biopsy of	30090	Proctocolectomy with ileostomy	32015,32018,32021
Pleural effusion	38803	Proctoscopy	*
Pleurectomy with thoracotomy	38424	Products of conception, retained, evacuation of	16564
Pleurodesis with thoracotomy	38424	Professional attendances	(see attendance)
Plexus, brachial, exploration of	39333	Profilometry, urethral pressure	11906,11909
Plication, intestinal, with enterolysis, Noble type	30375	Progesterone implant	14203,14206
Pneumonectomy	38438,38441	Prolonged professional attendance, lifesaving	160-164
Poison, ingested, gastric-lavage in the treatment of	14200	Proof puncture of maxillary antrum	41698,41701
Polycythemia	13757	Prostate, biopsy of	37212-37219
Polyhydramnios, attendance, not routine antenatal	16502	diathermy or visual laser destruction of	37224-37224
Polyp, anal, excision of	32142,32145	endoscopic laser ablation	37207,37208
aural, removal of	41506,41509	high energy transurethral microwave thermotherapy	37230,37233
cervix, removal of	35611	total excision of	37209,37210,37211
larynx, removal of	41852	transurethral microwave thermotherapy	37230,37233
nasal, removal of	41662,41665,41668	transurethral radio-frequency needle ablation	37201,37202
rectal, removal with sigmoidoscopy	32078,32081	Prostatectomy, endoscopic	37203,37206
uterus, removal of	35639,35640	open	37200
Polypectomy, with hysteroscopy	35633	radical	37210,37211
Popliteal artery, exploration of, for popliteal entrapment	34145	Prostatic abscess, endoscopic drainage of	37221
vessel, ligation or exploration, other	34103	abscess, open drainage of	37212
Porta hepatitis, radical resection for carcinoma	30461	coil, insertion of	37223
Portacath, laparotomy with insertion of	30400	Prosthesis, breast, manipulation fibrous tissue surrounding	*
Portal hypertension, operations for	30602-30606	breast, removal and/or replacement	45548-45555
Porto caval shunt for portal hypertension	30602	knee, removal of	49515
Portoenterostomy for biliary atresia	43978	oesophageal, insertion of	30490
Posterior chamber, removal of silicone oil	42815	shoulder, removal of	48927
sclerotomy	42734	Provocative test for glaucoma	11200
spinal fusion	40321,40324,40327	Pseudarthrosis, bone grafting of metatarsal for	46402,46405
vaginal compartment repair	35571,35573	bone grafting of phalanx for	46402,46405
Postero-lateral bone graft to spine	48648,48651	Psychiatry, by consultant psychiatrists	(see attendances)
Postnasal space, examination under GA	41653	Psychological therapy services	80000-80020
space, direct examination with/without biopsy	41761	Focussed psychological strategies	80100-80170
Postnatal care	16564-16573	Psychotherapy, by consultant psychiatrists	(see attendances)
Postoperative haemorrhage	30058	Pterygium, removal of	42686
- control under GA, independent	30058	Ptosis of eyelid, correction of	45623,45624,45625
- laparotomy for control of	30385	breast, correction of (unilateral)	45556,45557
- tonsils/adenoids, arrest, under GA	41796,41797	Public health physicians - attendances	410-417
following gynaecological surgery, under GA	35759	Pudendal and spinal nerve motor latency, measurement	11833
pain, control of	18206-18212	Pulmonary artery, banding of	38715,38718
Postpartum haemorrhage, treatment of	16567	artery catheterisation	13818
Pre-auricular sinus, excision of	30104	artery pressure monitoring, open heart	11627
Preeclampsia, treatment of	16509	-under 12 years of age	
Pregnancy, attendance for complication by	16508	decortication with thoracotomy	38421
- acute intercurrent infection		Pulp space infection of foot, incision for	47912
- diabetes or anaemia	16502	space infection of hand, incision for	46525
- intrauterine growth retardation	16508	Pulse generator, subcutaneous placement	39134
- threatened premature labour	16502,16508	Pump or reservoir, loading of	14218
Pregnancy support counselling	81000-81010	implanted, associated with adjustable gastric band	31441
multiple, attendance other than routine antenatal	16502	Punch biopsy of synovial membrane	30087
Premalignant skin lesions, treatment of	30192		

* Payable on attendance basis

Service	Item	Service	Item
Punctum, occlusion of snip operation	42620,42621,42622 42617	tumour, excision of 32103,32104,32106	32099,32102,32108
Purse string ligation, cervix string ligature of cervix, removal	16511 16512	Rectocele, perineal repair of vaginal compartment repair of	32131 35571
Puva therapy	14050,14053	Rectopexy, abdominal, of rectal prolapse	32117
Pyelography retrograde, preparation for	36824	Rectosigmoidectomy (Hartmann's operation)	32030
Pyelolithotomy	36540,36543	perineal, for rectal prolapse	32112
Pyeloplasty, by open exposure	36564,36567,36570	Rectosphincteric reflex, measurement of	11830
Pyeloscopy, retrograde	36652,36654,36656	Rectovaginal fistula, repair of	35596
Pyelostomy, open	36552	Rectum and anus, abdomino-perineal resection of	32039-32046
Pyloromyotomy for pyloric stenosis	43930	anterior resection of	32024-32028
Pyloroplasty	30375	examination under GA, paediatric	44102
reconstruction of	30517	perineal resection of	32047
Pylorus, dilation of, with vagotomy	30502	suction biopsy of	30071
Pyogenic granulation, cauterisation of	*	Recurrent hernia, repair of	30403
Pyonephrosis, drainage of	36537	Reduction mammoplasty (unilateral)	45520
		with surgical repositioning of nipple	45520
		without surgical repositioning of nipple	45522
		Reduction ureteroplasty	36618
		Refitting of contact lenses	10816
		Reflux, gastro-oesophageal, correction	43951,43954,43957
		vesico-ureteric, correction	36588
		Regional nerve block	(see nerve)
		Regitine phentolamine test for phaeochromocytoma	*
		Renal artery, aberrant, operation for	36537
		biopsy (closed)	36561
		cyst, excision of	36558
		dialysis in hospital	13100,13103
		function test	12524,12527
		pelvis, brush biopsy of, with cystoscopy	36821
		transplant	36503,36506,36509
		Reservoir, implanted associated with gastric band	14215,31441
		or pump, loading of	14218
		Respiratory function, estimation of	11503-11512
		Resuturing of wound following intraocular procedures	42857
		Retina, cryotherapy of	42728,42818
		detached, diathermy or cryotherapy for	42773
		detached, removal of encircling silicone band	42812
		detached, resection or buckling operation for	42776
		detached, revision operation for	42779
		light coagulation for	42782,42783
		photocoagulation of	42809
		pre-detachment of, cryotherapy for	42818
		Retinal photography	11215,11218
		Retrobulbar abscess, operation for	42572
		injection of alcohol	42824
		Retrolabyrinthine vestibular nerve section	41596
		Retroperitoneal abscess, drainage of	30402
		lymph node biopsies	35723
		lymph node dissection	37607,37610
		neuroendocrine tumour, removal of	30321,30323
		Retropharyngeal abscess, incision with drainage	30223
		Retropubic prostatectomy	37200
		Retroversion, operation for	35683,35684
		Rhinophyma, carbon dioxide laser ablation/excision	45652
		shaving of	45653
		Rhinoplasty procedures	45632-45644
		secondary revision of	45650
		Rhinotomy, lateral, with removal of tumour	41728
		Rhizolysis, spinal	40330
		Rib, cervical, removal of	34139
		first, resection of portion	34136
		fracture, treatment of	47471
		operation for acute osteomyelitis	43503

* Payable on attendance basis

Service	Item	Service	Item
operation for chronic osteomyelitis	43512	injection of starburst vessels, head/neck	30213,30214
osteectomy or osteotomy of	48406,48409	injection of telangiectases, head/neck	30213,30214
resection, with radical operation for empyema	38415	Scoliosis, treatment of	48606-48632
Ring fixator, adjustment of	50309	anterior correction of (Dwyer procedure)	48621-48624
Rod, plate or nail, removal of	47930	application of halo	47714
Rodent ulcer, operation for	(see ulcer,other)	bone graft to	50644
Rosen incision, myringoplasty	41527	congenital, vertebral resection and fusion for	48632,50640
Rotational atherectomy, of the coronary artery	38309-38318	re-exploration for	48615,50616
Rotator cuff of shoulder, repair of	48906,48909	requiring anterior decompression of spinal cord	48630,50636
Round window repair or cochleotomy	41614	revision of failed surgery	48618,50620
Roux-en-Y biliary bypass	30460,30466,30467	spinal fusion for	48606-48613
Rovsing's operation	36537	spinal fusion for, with segmental instrumentation	48612,48613,48627
Rubin test for patency of Fallopian tubes	35706	spinal fusion with use of Harrington rod	48681
Ruptured medial palpebral ligament, repair of	42854	treatment of including paediatric	50600-50644
membranes, threatened premature labour	16508	Screw, pin or wire, buried, removal of	47924,47927
muscle, repair of	30232,30235	Scrotal contents, exploration of	37604
thoracic aorta, operative management of	38572	Scrotum, excision of abscess of	30223
urethra, repair of	37306,37309	partial excision of	37438
viscus, simple repair of	30375	Sebaceous cyst, removal of	(see cyst,other)
repair of abdominal aortic aneurysm	33116,33119	Second trimester labour, management of	16525
rods, re-exploration for adjustment /removal	48615	Secondary, repair of extensor tendon of hand or wrist	46423
		repair of flexor tendon of hand or wrist	46429
		Segmentectomy	38438
S		Selective coronary angiography	38215-38246
SIR-Spheres administration	35404,35406,35408	internal radiation therapy	35404,35406,35408
Sacral sinus, excision of	30675,30676	Semen, collection of	13290,13292
colpopexy	35597	Semimembranosus bursa, excision of	30114
nerve stimulation for faecal incontinence	32213-32218	Seminal vesicle/ampulla of vas, total excision of	37209
sympathectomy	35012	Sengstaken-Blakemore tube, insertion of	13506
Sacro-iliac joint, arthrodesis of	49300	Sentinel lymph node biopsy for breast cancer	30299-30303
joint disruption, treatment of	47513	Septal defect, atrial, closure of	38742
Sacrococcygeal and presacral tumour, excision of	32036	defect, ventricular, closure of	38751
teratoma, neonatal, excision of	43876,43879	perforation, closure of	41671
Salivary gland, major, transposition of duct	41910	Septectomy, cardiac	38739,38748
gland, operations on	30262-30269	Septoplasty of nasal septum	41671
Salpingectomy, laparoscopic	35638	Septostomy, or balloon valvuloplasty	38270
with laparotomy, not with hysterectomy	35712-35717	Septum button, nasal, insertion of	41907
with vaginal hysterectomy	35673	nasal, cauterisation/diathermy	41674
Salpingo-oophorectomy not with hysterectomy	35712-35717	nasal, reconstruction of	41672
Salpingolysis	35694,35697	nasal, septoplasty or submucous resection	41671
Salpingostomy	35694,35697	vaginal, excision of, for correction of double vagina	35566
laparoscopic	35638	Sequestrectomy	43512-43524
Saphenous vein anastomosis	34809	Seroma, breast, exploration, drainage, operating theatre	31551
Scalene node biopsy	30096	Sesamoid bone, osteotomy or osteectomy of	48400
Scalenotomy	34133	Seton, readjustment of, in anal fistula	32166
Scalp vein catheterisation in a neonate	13300	Shirodkar suture	16511
Scaphoid, bone graft to	48230,48233,48236	Shoulder, amputation or disarticulation at	44331
Scapula, fracture, treatment of	47468	Stabilisation procedure for recurrent anterior or posterior	
(other than acromion), osteectomy/osteotomy	48406,48409	dislocation	48930
operation for chronic osteomyelitis	43512	arthrectomy or arthrodesis	48939,48942
Scar, abrasive therapy to	45021,45024	arthroscopic surgery	48948-48960
face or neck, revision of (restriction applies)	45506,45512	arthroscopy	48945
in oral and maxillofacial region	45801-45807	arthrotomy	48912
other than face or neck, revision of (restriction)	45515,45518	dislocation, treatment of	47009,47012,47015
other, removal of	31200-31240	hemi-arthroplasty of	48915
Scars, corneal, removal of, by partial keratectomy	42647	nerve block for post op pain	18212
Schilling test	12512,12515	open reduction for congenital dislocation	50408
Sclera, removal of imbedded foreign body	42644	orthopaedic treatment of	48900,48903
removal of superficial foreign body	30061	prosthesis, removal of	48927
transplantation of	42662,42665	removal of calcium deposit from cuff	48900
Scleral blood vessels, laser coagulations of	42797	rotator cuff, repair of	48906,48909
graft to lid	42860	spica, application of	47540
Sclerectomy and iridectomy for glaucoma	42746	stabilisation, for multidirection instability	48933
Sclerosant fluid, injection of into pilonidal sinus	30679	synovectomy of	48936

* Payable on attendance basis

Service	Item	Service	Item
total replacement of	48918,48921,48924	Spasticity management	
Shunt, aorto-pulmonary or cavo-pulmonary	38733,38736	implanted drug delivery system	14227-14242
arteriovenous, external, insertion/removal	34500,34506	Specialist attendance	(see attendance)
cranial or cisternal, insertion of	40003	Specimen of sweat, collection of, by iontophoresis	12200
cranial or cisternal, revision or removal of	40009	Speech discrimination tests	11321
lumbar, insertion of	40006	Spermatic cord, exploration of, inguinal approach	30644
lumbar, revision or removal of	40009	Spermatocoele, excision of	37601
Sigmoidoscopic examination	32072,32075	Sphenoidal sinus, intranasal operation on	41752
- with diathermy or resection of polyp/s	32078,32081	Sphincter, anal, direct repair of	32129
Sigmoidoscopy, fiberoptic, flexible	32084,32087	anal, stretching of	32153
Silicone band, encircling, removal from detached retina	42812	bladder, endoscopic incision/resection	36854
breast prosthesis, removal of	45555	muscle and pelvic floor abnormalities, diagnosis of	11833
Sinoscopy	41764	of Oddi, transduodenal operation on	30458
Sinus, diathermy of	*	urethral, reconstruction	37375
ethmoidal, external operation on	41749	urinary, artificial, insertion	37381,37384,37387
excision of	30099,30102,30103	urinary, artificial, revision or removal	37390
frontal, catheterisation of	41740	Sphincterotomy, anal, independent procedure	43999
frontal, radical obliteration of	41746	endoscopic	30485,36854
frontal, trephine of	41743	Spinal and pudendal nerve motor latency, measurement	11833
injection of sclerosant fluid under anaesthesia	30679	catheter, insertion of for infusion device	39125,39128
intranasal operation on	41737	cord, cervical decompression	40331-40335
maxillary, drainage of, through tooth socket	41719	fusion to cervical, thoracic or lumbar regions	48660-48675
pilonidal, excision of	30675,30676	fusion, application of halo for scoliosis	47714
pre-auricular, excision of	30104	fusion, posterior	40321,40324,40327
sphenoidal, intranasal operation on	41752	fusion, posterior interbody, with laminectomy	48654,48657
urogenital, vaginal reconstruction for	35565	nerves, injection into	39013
Skin, biopsy of	30071	nerves, percutaneous neurotomy	39115
cancer, treatment of	30196-30205	neurostimulator receiver, subcutaneous placement	39134
full face chemical peel	45019,45020	rhizolysis	40330
graft to orbit	42524	shunt for hydrocephalus	40006
grafts	(see graft)	spinal stimulation, for pain	39131-39139
lesions, multiple injections for	30207	stenosis, laminectomy for	40303,40306
lesions, treatment of	30192,30195	thoracic decompression	40345,40348
malignant lesion, removal of	31300-31335	thoraco-lumbar/high lumbar decompression	40351
repair of recent wound of	30026-30049	using segmental instrumentation	48613
sensitivity testing for allergens	12000,12003	Spine, application of plaster jacket to	47708
subcutaneous tissue, extensive excision	31245	application of a localiser cast to	50600
tags, anal, excision of	32142,32145	bone graft to	48642-48651
Skull base surgery for tumour removal	39640-39662	fracture, treatment of	47681-47702
base tumour, removal, infra-temporal	41581	internal fixation of	48678-48690
calipers, insertion of	47705	manipulation of	48600,48603
fracture, attendance for treatment of	47703	operation on, for acute osteomyelitis	43509
fractured, operations for	39606-39615	operation on, for chronic osteomyelitis	43518
osteomyelitis, acute, operation for	43503	Spirometry	11506,11509
osteomyelitis, chronic, operation for	43521	Spleen, ruptured, repair of	30375
osteomyelitis, craniectomy for	39906	Splenectomy	30597,30599
treatment of fracture, not requiring operation	47703	laparoscopic	31470
tumour, excision of	39700	Spleno renal shunt, selective, for portal hypertension	30605
Sleep apnoea, overnight investigation for	12203,12207	Splenorrhaphy	30596
Overnight paediatric investigation	12210,12213,12215	Split skin free grafts, granulating areas	45400,45403
12217		skin free grafts to one defect	45439-45448
Sling operation for stress incontinence	35599	Sports physicians, attendances by medical practitioners who are	
procedure, intestinal, prior to radiotherapy	32183	sports physicians	444-449
Slough, debridement of	35100,35103	Squamous cell carcinoma, removal of	31255-31295
Small bone, exostosis, excision of	47933	Squint, muscle transplant (Hummelsheim type)	42848
bowel intubation	30487,30488	operation for	42833-42842
bowel stricturoplasty	30564	readjustment of adjustable sutures	42845
bowel, endoscopic examination of	32095	recurrent, operation for	42851
intestine, resection of	30565,30566	Staging laparotomy for gynaecological malignancy	35726
Small bowel, capsule endoscopy, investigation of obscure		Stapedectomy	41608
bleeding	11820	Stapes mobilisation	41611
Smith's fracture of radius, treatment of	47369,47372,47375	Staple arrest of hemi-epiphysis	48509
Smith-Petersen nail, removal of	47924,47927	Starburst vessels, head/neck, diathermy or injection	30213,30214
Socket, eye, contracted, reconstruction of	42527	Stenosing tendovaginitis, hand/wrist, open operation	46363

* Payable on attendance basis

Service	Item	Service	Item
Stenosis, arteriovenous fistula/access device, correction of	34518	Submandibular abscess, incision of	30223
auditory canal, correction of	41521	ducts, relocation of	30255
spinal, laminectomy for	40303,40306	gland, extirpation of	30256
tracheal, dilatation of, with bronchoscopy	41904	Submaxillary gland, repair of cutaneous fistula	30269
venous, operations for	34812,34815	Submucous resection of nasal septum	41671
Stent, external, application restore valve competency	34824-34833	resection of turbinates	41692
insertion, transluminal	35306,35309,35307	Subperiosteal abscess	43500-43524
insertion, transluminal, rotational atherectomy	38312,38318	Subphrenic abscess, laparotomy for drainage of	30394
ureteric, passage through nephrostomy tube	36604	Subtalar arthrodesis	50118
Stereotactic procedures	40800,40801,40803	Subtemporal decompression	40015
radiosurgery		Subungual haematoma, incision of	30219
Sterilisation (female)	35687,35688	Suction biopsy of rectum	30071
in conjunction with Caesarean section	35691	curettage of uterus	35639,35640,35643
Sternal wire/s, removal of	38460	Supraglottic laryngectomy with tracheostomy	41840
Sternocleidomastoid muscle, bipolar release, torticollis	50402	Suprapubic cystostomy or cystotomy	37008
Sternotomy for removal of thymus or mediastinal tumour	38446	cystostomy tube, change of	*
involving division of adhesions	38643,38647	prostatectomy	37200
median, for post-operative bleeding	38656	stab cystotomy	37011
wound, debridement of	38462,38464	Surgical reduction of enlarged elements, macrodactyly	46510
Sternum and mediastinum, reoperation for infection	38468,38469	wounds, resuturing of (not burst abdomen)	*
biopsy of	30081,30084,30087	Suspension of uterus	35683,35684
fracture, treatment of	47466,47467	Suture, laser division of, eye, following trabeculoplasty	42794
operation for acute osteomyelitis	43503	shirodkar	16511
operation for chronic osteomyelitis	43512	traumatic wounds	30026-30049
reoperation for dehiscence or infection	38466	Sutures, adjustable, readjustment of, for squint	42845
Stomach lavage	*	dressing and removal of, requiring GA	30055
lavage in the treatment of ingested poison	14200	Swann-Ganz catheterisation	13818
Stone/s, biliary/renal tract, extraction of	(see calculus)	Sweat, collection of specimen of, by iontophoresis	12200
removal of, by urethroscopy	36540,36543	gland bearing area, excision of	30180,30183
Strabismus, operation for	42833-42839	Sycosis barbae/nuchae, excision of	31245
botulinum toxin injection, for	18362	Symblepharon, grafting for	45629
operation for		Syme's amputation of foot	44361
Stress incontinence, abdomino-vaginal operation	35602,35605	Sympathectomy, chemical	(see nerve blocks)
treatment by maximal perineal stimulation	*	surgical	35000-35012
Marshall-Marchetti, urethropexy	35599,37044	Symphysis pubis, fracture, treatment of	47474-47489
Stamey or similar type needle colposuspension	37043	Synacthen stimulation testing	30097
sling operation	35599,37042	Syndactyly, repair	(see flap repair)
suprapubic procedure for	37044	Synechia, division of	42761
Stricture, anal, anoplasty for	32123	Synovectomy, of ankle	50312
oesophagus, dilatation of	41819	of elbow	49109
rectal, dilatation of	32115	of finger joints	46336
rectum, plastic operation to	30387	of hand tendons	46336,46342
tracheal, dilatation of, with bronchoscopy	41904	of joint, not otherwise covered	50104
urethral, dilatation of	37303	of metatarso-phalangeal joint	49860,49863
Strictureplasty, small bowel	30564	of shoulder	48936
Strontium 89, administration of	16015	of tendons of digit	46348-46360
Stump, amputation, reamputation of	44376	total, of knee	49509
amputation, trimming of	*	total, of wrist	49224
cervix-residual, removal of, abdominal approach	35612	Synovial cavity, aspiration of	50124,50125
cervix-residual, removal of, vaginal approach	35613	membrane, punch biopsy of	30087
Styloid process of temporal bone, removal of	30244	sacrospinous colpopexy	35568
Sub-valvular structures, heart, reconstruction, re-implant	38490		
Subclavian artery, endarterectomy	33506	T	
to femoral bypass grafting	32715	Talipes equinovarus, cast/manipulation/splint	49878
vessel, ligation/exploration, other	34103	equinovarus, procedures for	50315-50330
Subcutaneous fasciotomy, Dupuytren's contracture	46366	Talus fracture, treatment of	47606-47618
fistula in ano, excision of	32156	vertical, congenital, reconstruction	50336
foreign body, removal not otherwise covered	30064	Tantalum markers, surgical insertion of	42805
tenotomy	47960	Tarsometatarsal joint, fracture, treatment of	47621,47624
tissue, repair of recent wound of	30026-30049	joint, Lisfranc's amputation of	44364
Subdural haemorrhage, tap for	39009	Tarsorrhaphy	42584
Sublingual gland, duct, removal of calculus	30265,30266	Tarsus, dislocation, treatment of	47063,47066
gland, extirpation of	30259	fracture, treatment of	47627,47630
gland, meatotomy or marsupialisation	30265,30266		

* Payable on attendance basis

Service	Item	Service	Item
operation on, for acute osteomyelitis	43503	Thigh, amputation through	44367
operation on, for chronic osteomyelitis	43512	hamstring tendon transfer	50357,50360
osteectomy or osteotomy of	48406,48409	rectus femoris tendon transfer	50357
Tear duct, probing of	42610-42615	Third degree tear, repair of	16573
third degree, repair of	16573	ventriculostomy	40012
Teflon injection, into vocal cord	41870	Thompson arthroplasty of hip	49315
injection, peri-urethral	37339	Thoracic aneurysm, replacement by graft	33103
Telangiectases, head/neck, diathermy or injection of	30213,30214	aorta, operative management of rupture/dissection	38572
Temperature, digital, measurement of	11615	aorta, repair or replacement procedures	38550-38571
Temporal artery, biopsy of	34109	cavity, aspiration of	38800,38803
bone, reconstruction of	45788	decompression of spinal cord	40345,40348
bone, removal of styloid process of	30244	outlet compression, removal operation	34139
bone, resection for removal of tumour	41584,41587	sympathectomy	35003,35006
Temporomandibular joint, arthroplasty	45758	Thoraco-lumbar decompression of spinal cord	40351
arthrodesis	45877	Thoracoplasty	38427,38430
arthroscopy of	45855,45857	Thoracoscopy	38436
arthrotomy	45859	Thoracotomy	38418,38421,38424
joint, external fixation, application of	45879	and excision of cyst/teratoma	43912
joint, irrigation of	45865	for congenital cystadenomatoid malformation	43861
joint, manipulation of	45851	for congenital lobar emphysema	43861
joint, open surgical exploration of	45861-45873	for oesophageal atresia, neonatal	43852
meniscectomy	45755	for removal of thymus or mediastinal tumour	38446
stabilisation of	45875	involving division of adhesions	38643,38647
synovectomy of	45867	or median sternotomy for post-operative bleeding	38656
Temporosphenoidal electroencephalography	11006	Threatened abortion, treatment of	16505
Tendon	49718-49727	miscarriage, purse string ligation of cervix	16511
- Achilles, repair of	49718-49727	miscarriage, treatment of	16505
- artificial prosthesis, insertion of for grafting	46414	premature labour, treatment of	16502,16508
- foot, adductor hallucis, transfer of	49827,49830	Three snip operation	42617
- foot, repair of	49800-49812	Thrombectomy of arteriovenous access device	34515
- foreign body in, removal	30067,30068	of artery or vein	33803,33806,33812
- hand/digit, synovectomy of	46336-46360	Thrombosis, peri-anal, incision of	32147
- hand/wrist, repair of	46420-46435	reoperation on extremity for	33848
- lengthening of	47957,47960,47963	Thrombus, removal of	33803,33806,33812
- major, of ankle, repair of	49718-49727	Thumb, digital nail, removal of	46513,46516
- or ligament transfer	47966	flexor tendon sheath, open operation	46522
- prosthesis, artificial, insertion for grafting	46414	fractures, treatment of	47300-47333
- reconstruction of, by tendon graft	46408	ingrowing nail, resection	46528,46531
- repair of	47954,49718	nodule, removal of	(see tumour,other)
- sheath, open operation for tenovaginitis	46363,47972	Thymectomy	38456
- tenotomy	47960,47963	Thymoma, malignant, removal from mediastinum	38456
- transfer of, to restore elbow function	50405	Thymus, removal of by thoracotomy or sternotomy	38446
- transfer of, to restore hand function	46417	Thyroglossal cyst and/or fistula, removal of	30313,30314
- transplantation of	47966	Thyroid uptake	12518
Tenolysis, hand	46450,46453	Thyroidectomy	30296-30310
Tenoplasty	47963	Thyrotropin alfa-rch, administration of	12201
Tenosynovectomy	47969	Tibia, bone graft to	48206,48209
Tenosynovitis, open operation, tendon sheath hand/wrist	46363	congenital deficiency, treatment of	50417,50423
Tenotomy	47960,47963,49806	congenital pseudarthrosis, resection, fixation	50354
49809		epiphyseodesis	48503,48506
percutaneous, of finger	46456	fracture, treatment of	47543-47573
Tenovaginitis, open operation for	46363,47972	fracture, treatment of paediatric	50580-50588
Tensillon test	*	operation on, for acute osteomyelitis	43503
Teratoma, mediastinal, thoracotomy and excision	43912	operation on, for chronic osteomyelitis	43512
sacrococcygeal, neonatal, excision of	43876,43879	osteectomy or osteotomy of	48418,48421
Testicular implant	45051	Tibial vessel, ligation/exploration not otherwise covered	34106
Testis, exploration of	37604	Tic douloureux, injection for	39100
impalpable, exploration of groin	37812	Tilt table testing for investigation of syncope	11724
undescended, orchidopexy for	37803,37806,37809	Tissue, expansion for breast reconstruction	45539,45542
Testopexy	37803	expander, insertion of	45566
Tethered cord, release of	40112	expander, removal of	45568
Thenar spaces of hand, drainage of	46519	expansion, intra-operative	45572
Therapeutic haemapheresis	13750	free transfer of	45563,45564,45565
Therapeutic venesection	13757	living, implantation of	14203,14206

* Payable on attendance basis

Service	Item	Service	Item
subcutaneous, repair of recent wound of	30026-30049	Transorbital ligation of ethmoidal arteries	41725
Toe, amputation or disarticulation of	44338-44358	Transplantation, cornea	42653,42656,42659
dislocation, treatment of	47069,47072	ligament or tendon	47966
fracture, simple, treatment of	*	ureter	36585-36603
fractures, treatment by reduction	47663-47678	Transposition of digit	46507
hammer or claw, correction of	49848,49851	of nerve	39321
hyperextension deformity, release, lengthening	50345	Transpupillary thermotherapy	42811
phalanx of, operation for acute osteomyelitis	43500	Transthoracic drainage of pericardium	38450
Toenail, ingrowing, excision or resection for	47915,47916,47918	Transtympanic removal of glomus tumour	41620
ingrown, operation with GA, paediatric	44136	Transurethral injection for urinary incontinence	37339
removal of	47904,47906	Transvenous electrode/s, permanent, insertion of	38350,38356
Tongue, partial or complete excision of	30272,41779,41782	pacemaking electrode, temporary, insertion of	38256
41785		Treacher Collins Syndrome, peri-orbital correction of	45773
tie, repair of	30278,30281	Trephine of frontal sinus	41743
Tonography, one or both eyes	11203	Trichiasis, treatment of	42587
Tonsils, lingual, removal of	41804	Trichoepitheliomas, face/neck, removal by laser excision	30190
or tonsils and adenoids	41796,41797	Trigeminal gangliotomy, radiofrequency/balloon/glycerol	39109
- arrest of haemorrhage, requiring GA		nerve, injection with alcohol, cortisone etc	39100
- removal of, twelve years or over	41792,41793	neuralgia, intracranial neurectomy	39106
- removal of, under twelve years	41788,41789	Trigger finger, correction of	46363
Topectomy, for epilepsy	40703	Tube pedicle or indirect flap	45230
Torkildsen's operation	40000	- delay of	
Torticollis, bipolar release sternocleidomastoid muscle	50402	- formation of	45227
operation for	44133	- preparation of site and attachment to site	45233
Trabeculectomy for glaucoma	42746,42783	- spreading of pedicle	45236
Trabeculoplasty, laser, of eye	42782	Tuboplasty	35694,35697
Trachea, dilatation of stricture and stent insertion	41905	Tumour, adrenal gland, excision of	30324
removal of foreign body from	41886	benign, of soft tissue, removal	31350
Tracheal excision, repair, with cardiopulmonary bypass	38455	bladder, diathermy/resection with cystoscopy	36845,36840
excision, repair, without cardiopulmonary bypass	38453	bladder, laser destruction with cystoscopy	36840
stricture, dilatation of with bronchoscopy	41904	bone, benign, requiring allograft, resection of	50230
Trachelorrhaphy	35617,35618	bone, innocent, excision of	30241
Tracheo-oesophageal fistula, division and repair	43900	bone, malignant, operations for	50200-50239
formation of, including endoscopic procedures	41885	broad ligament, removal of	35712-35717
Tracheomalacia, aortopexy for	43909	cardiac, excision of	38670-38680
Tracheoplasty or laryngoplasty with tracheostomy	41879	carotid body, resection of	34148,34151,34154
Tracheostomy		cerebello-pontine angle, removal of	41575-41579
by open exposure of the trachea	41881	deep, peripheral nerve, removal of	39327
closure of	30102,30103	endocrine, exploration of	30578,30580,30581
percutaneous technique, sequential dilation, partial splitting		extradural, laminectomy for	40309
method	41880	face/neck, laser excision	30190
using Minitrach or similar device	41884	gastric, removal of	30520
with laryngoplasty or tracheoplasty	41879	glomus, removal of	41620,41623
with supraglottic laryngectomy	41840	gynaecological, radical or debulking operation	35720
with vertical hemi-laryngectomy	41837	intra-oral, radical excision of	30275
Transanal		intra-temporal fossa, removal of	41578
transanal endoscopic microsurgery	32103,32104,32106	intracerebral, craniotomy and removal of	39709
Transantral ethmoidectomy with radical antrostomy	41713	intracranial, biopsy/decompression, osteoplastic flap	39706
ligation of maxillary artery	41707	intracranial, burr-hole biopsy or drainage	39703
vidian neurectomy	41713	intracranial, craniotomy and removal of	39709,39712
Transcranial doppler	11614	intramedullary, laminectomy for	40318
Transfusion	13703,13706	involving ciliary body an/or iris, excision of	42767
collection of blood for	13709	iris, excision of	42764
paediatric/neonatal	13306,13309	larynx, removal of	41852
Transillumination, ocular	42821	limbic, removal of	42692
Translabyrinthine vestibular nerve section	41593	lipoma, liposuction or surgical removal of	31345
Transluminal balloon angioplasty	35300-35303	malignant of soft tissue, removal of	31355
rotational atherectomy with stent insertion	38312,38318	malignant upper aerodigestive tract	31400,31403,31406
rotational atherectomy without stent insertion	38309,38315	malignant, bone, operations for	50200-50239
stent insertion	35306,35309	malignant, skin, removal of	31300-31335
Transmastoid decompression of endolymphatic sac	41590	mandible, segmental resection for	45605
removal of glomus tumour	41623	mediastinal, removal by thoracotomy or sternotomy	38446
Transmetacarpal amputation of hand	44325	microlaryngoscopy with removal of	41864
Transmetatarsal amputation of foot	44364	neuroendocrine, removal of	30321,30323

* Payable on attendance basis

Service	Item	Service	Item
other, removal of (restriction applies)	31200-31240	Upright tilt table testing for syncope	11724
ovarian, radical or debulking operation for	35720	Urachus, patent, excision of	37800
parapharyngeal, excision of, cervical approach	31409,31412	Urea breath test	12533
parathyroid, removal of	30306	Ureter, brush biopsy of, with cystoscopy	36821
parotid gland, removal of	30253	divided, repair of	36573
parotid, excision of	30251	exploration of	36612
peripheral nerve, removal from	39324,39327	retrocaval, correction of, by open exposure	36564,36567
pituitary, hypophysectomy or removal of	39715	transplantation of	36597
rectal, excision of	32099,32102,32108	- into another ureter	
removal of, by laminectomy	40309,40318	- into bladder	36588,36591
removal of, by lateral rhinotomy	41728	- into intestine	36594
removal of, by neurectomy, neurotomy	39327	- into isolated intestinal segment	36600,36603
removal of, by temporal bone resection	41584,41587	- into skin	36585
removal of, by urethrectomy	37330	Ureterectomy	36579
removal of, in oral and maxillofacial region	45801-45813	Ureteric calculus, endoscopic extraction/manipulation	36857
sacrococcygeal and presacral, excision of	32036	catheterisation with cystoscopy	36818,36824
skin, malignant, removal of	31300-31335	dilatation	36821
skin, micrographic serial excision	31000,31001,31002	meatotomy	36830
skull base, removal of	39640-39662	reflux, correction of	36588
skull, excision of	39700	stent, insertion of	36821,36605,36607
spinal, laminectomy for	40318	stent, removal/replacement of	36825
thyroid, removal of	30310	stent, through nephrostomy tube	36604
vagina, simple, removal of	35557	Ureterolithotomy	36549
vocal cord, removal from	41852	complicated by previous surgery	37444
Tunnelled cuffed catheter		Ureterolysis	36615
central vein, for haemodialysis or parenteral nutrition	34538	Ureteroplasty	36618
removal	34539	Ureteroscopy	36803,36806,36809
Turbinates, cauterisation or diathermy of	41674	Ureterostomy, cutaneous, closure of	36621
dislocation, treatment of	41686	revision of	36609
submucous resection of	41692	Urethra, cauterisation of	35523
Turbinectomy	41689	diathermy of	37318
Turriccephaly, cranial vault reconstruction for	45785	diverticulum, excision of	37372
Tympani, paracentesis of	41626	endoscopic examination with cystoscopy	36812
Tympanic membrane, micro-inspection of	41650	laser therapy, intraepithelial neoplasia	35539,35542,35545
membrane, micro-inspection with ear toilet	41647	prolapsed, excision of	37369
Tympanum, perforation, cauterisation or diathermy	41641	ruptured, repair of	37306,37309
tuberosus, tubular or constricted breast, treatment by	45559	Urethral abscess, drainage of	30223
		caruncle, cauterisation of	35523
		caruncle, excision of	35526,35527
		dilatation with cystoscopy	36812
		diverticulum, excision of	37372
		fistula, closure of	37333,37336,37833
		pressure profilometry	11906,11909
		prosthesis, with cystoscopy	36811
		reconstruction, hypospadias/epispadias	37815,37827,37830
		sounds, passage of, as an independent procedure	37300
		sphincter, reconstruction of	37375
		stricture, dilatation of	37303
		stricture, optical urethrotomy for	37327
		stricture, plastic repair of	37342-37351
		tumour, removal of by urethrectomy	37330
		valves, destruction of	37854
		warts, cystoscopy for the treatment of	36815
		Urethral sling, division or removal of	37340,37341
		Urethrectomy	37330
		Urethrocoele, repair of	35570
		repair of	35570,35573
		Urethropexy (Marshall-Marchetti operation)	35599,37044
		Urethroplasty	37342-37351
		Urethroscopy, as an independent procedure	37315
		with biopsy/diathermy/foreign body/stone	37318
		with cystoscopy	36812
		with cystoscopy and injection for incontinence	37339
		with laser destruction of stone	37318
U			
UVB therapy	14050,14053		
Ulcer, corneal, epithelial debridement for	42650		
corneal, ionisation of	*		
duodenal, perforated, suture of	30375		
gastric, perforated, suture of	30375		
other, removal of	31200-31240		
peptic, bleeding, control of	30505-30509		
peptic, perforated, suture of	30375		
Ulna, bone graft to	48218-48227		
fracture, treatment of	47360-47408		
fracture, treatment of paediatric	50500-50540		
operation on, for acute osteomyelitis	43503		
operation on, for chronic osteomyelitis	43512		
osteectomy or osteotomy of	48406,48409		
Ulnar vessel, ligation/exploration not otherwise covered	34106		
Ultrasonic localisation of placenta, Doppler technique	*		
Ultrasound, intraoperative, biliary tract	30439		
staging of intra-abdominal tumours	30441		
Umbilical artery catheterisation	13303		
granuloma, excision under GA	43948		
hernia, repair of	30616-30621		
vein catheterisation in a neonate	13300		
Undescended testis, orchidopexy for	37803,37806,37809		
Unstable lie, attendances other than routine antenatal	16502		

* Payable on attendance basis

Service	Item	Service	Item
Urethrostomy	37324	replacement, heart	38488,38489
Urethrotomy, external or internal	37324	Valvotomy for pulmonary stenosis	38456
optical, for urethral stricture	37327	open, of mitral valve	38487
Urinary conduit or reservoir, endoscopic examination	36860	Valvuloplasty, balloon or septostomy	38270
conduit, revision of	36609	Varicocele, surgical correction of	30634,30635
infection, bladder washout test	11921	Varicose veins, injection of sclerosing fluid	*
reservoir, formation of	36606	veins, multiple injections	32500,32501
sphincter, artificial	37381,37384	veins, operations for	32500-32517
- insertion of cuff		Vas deferens, operations on	37616-37623
- insertion of pressure regulating balloon, pump	37387	Vasectomy	37622,37623
- revision or removal of	37390	Vasoeppidymostomy (unilateral)	37616,37619
Urine flow study	11900	Vasotomy	37622,37623
Urogenital sinus, vaginal reconstruction for	35565	Vasovasotomy	37616,37619
Uterine adenomyoma, excision of	35649	Vein, anastomosis, microsurgical	45502
adhesiolysis, with hysteroscopy	35633	bypass for venous stenosis or occlusion	34812
adhesions, laparoscopic division	35638	cannulation of, in a neonate	13300
adnexae, removal, with abdominal hysterectomy	35653	central, catheterisation	13318,13319,13815
artery embolisation	35410	central, catheterisation, subcutaneous tunnel	34527,34528
lavage, (saline flushing)	*	femoral bypass, saphenous vein anastomosis	34809
myomectomy	35649	graft for priapism	37396
septum, hysteroscopic resection	35623	great, ligation or exploration not otherwise covered	34103
tubes, insufflation of, for patency (Rubin test)	35706	harvesting, leg/arm, for bypass, not same limb	32760
Utero-sacral ligaments, laparoscopic division	35638	harvesting, leg/arm, for patch graft, not same incision	33551
Uterus, acute inversion, vaginal correction	16570	intra-abdominal, cannulation, infusion chemotherapy	34521
bicornuate, plastic reconstruction for	35680	ligation or exploration not otherwise covered	34106
curettage of	35639,35640	major, repair of wound of	33815-33839
debulking prior to vaginal hysterectomy	35658	patch grafting to	33545,33548
gravid, evacuation of contents	35643	saphenous, cross leg by-pass graft	34806
implantation of Fallopian tubes into	35694,35697	scalp, catheterisation of	13300
suspension or fixation of	35683,35684	stenosis, patch angioplasty for	34815
Uvula, excision of	41810	thrombectomy of	33810,33811,33812
Uvulectomy and partial palatotomy	41787	transplant to restore valvular function	34821
Uvulopalatopharyngoplasty	41786	umbilical, catheterisation of	13300
Uvulotomy	41810	varicose, injection of sclerosing fluid	*
		varicose, multiple injections	32500,32501
		varicose, operations for	(see varicose)
		Veins, major, access as part of re-operation	35202
		Velopharyngeal incompetence, flap or pharyngoplasty	45716
		Vena cava, inferior, operations on	34800,34803
		caval filter, insertion of	35330
		Venepuncture for sending blood to Approved Pathologist	*
		Venesection	*
		therapeutic	13757
		Venography, operative	35200
		Venous anastomosis, not otherwise covered	32766,32769
		catheterisation, peripheral	35317,35319,35320
		stenosis or occlusion, vein bypass for	34812
		valve, plication or repair to restore competency	34818
		Ventilation, mechanical, intensive care	13882,13857,13881
		Ventral hernia following closure exomphalos, repair of	43939
		hernia, repair of	30403
		Ventricular aneurysm, plication of	38506
		aneurysm, resection	38507,38508
		assist device, insertion of	38615,38618
		assist device, removal of, independent	38621,38624
		augmentation	38766
		chamber, operation for arrhythmia	38518
		myomectomy	38763
		puncture	39006
		reservoir or external drain, insertion of	39015
		septal defect, closure of	38751
		septal rupture, ischaemic, repair of	38509
		septectomy	38748
		Ventriculo-cisternostomy	40000

* Payable on attendance basis

Service	Item	Service	Item
Ventriculostomy, third	40012	arthroplasty of	49209
Vermilionectomy	45668,45669	arthroscopic surgery	49221,49224,49227
Version, external cephalic	16501	arthroscopy of	49218
Vertebra, needle biopsy of	30093	arthrotomy of	49212
Vertebral bodies, fracture, treatment of	47681-47702	fracture, treatment of	47369,47372,47375
bodies, total or sub-total, excision of	48639	osteoplasty	49224
diseases of, excision & spinal fusion for	48640	proximal carpectomy	49206
resection and fusion for congenital scoliosis	48632	reconstruction of	49215
Vertebroplasty, for vertebral compression fracture	35400	revision arthroplasty	49210,49211
for vertebral metastatic deposit or multiple myeloma	35402	tendon sheath, open operation	46363
Vesical fistula, cutaneous, operation for	37023	tendon, repair of	46420-46435
Vesico-intestinal fistula, closure of	37038	Wry neck, operation for	44133
Vesicostomy, cutaneous, establishment of	37026		
Vesicovaginal fistula, closure of	37029	X	
Vestibular nerve section, retrolabyrinthine	41596		
nerve section, translabyrinthine	41593	Xanthelasma, treatment of	(see tumour,other)
nerve section, via posterior fossa	39500	Xenon arc photo-coagulation	42782,42783
Vestibuloplasty, unilaterla or bilateral	45837		
Vidian neurectomy, transantral, with antrostomy	41713	Z	
Villus, chorionic, sampling	16603		
Viscera, abdominal, operation involving laparotomy	30387	Z-plasty, in association with Dupuytren's Contracture	46384
pelvic, operation involving laparotomy	30387	Zinc ionisation of nostrils in the treatment of hay fever	*
Viscus, ruptured, simple repair of	30375	Zygo-apophyseal joint, injection into	39013
Vitamin products, injection of	*	Zygoma, osteotomy or osteectomy of	45720-45752
Vitello intestinal duct, patent, excision of	43945	Zygomatic arch, reconstruction of	45788
intestinal remnant, abdominal wall, excision of	43942	bone, fracture, treatment of	47762-47771
Vitreotomy	42719,42722,42725		
Vitreolysis of lens material	42791,42792		
Vocal cord, biopsy of	41849		
cord, removal of nodule or tumour	41852		
cord, teflon injection into	41870		
Volvulus, reduction of	30375		
Vulva, biopsy of, with colposcopy	35615		
laser therapy for intraepithelial neoplasia	35539,35542,35545		
wide local excision of suspected malignancy	35536		
Vulval warts, removal under GA or nerve block	35507,35508		
Vulvectomy, hemi	35536		
radical for malignancy	35548		
Vulvoplasty, where medically indicated	35533		
W			
Warts, anal, removal under GA or nerve block	32177,32180		
palmar or plantar, removal of	30186,30187		
penile or urethral, cystoscopy for treatment of	36815		
removal in operating theatre	30189		
vulval/vaginal, removal, GA or nerve block	35507,35508		
Webbed fingers/toes, repair (see osteotomy and/or flap repair)			
Wedge excision for axillary hyperhidrosis	30180		
excision of lip, eyelid or ear, full thickness	45665		
Wertheim's operation	35664		
Whipple's operation (pancreatico-duodenectomy)	30584		
Whole body count	12530		
Wire, orthopaedic, insertion of	47921		
pin or screw, buried, removal of	47924,47927		
Wolfe graft	45451		
Wound, debridement under GA or major block	30023		
dressing of, requiring GA	30055		
recent, repair of by sticking plaster	*		
resuturing following intraocular procedures	42857		
surgical, resuturing of (not burst abdomen)	*		
traumatic, suture of	30026-30049		
Wrist, arthrodesis of	49200,49203		

* Payable on attendance basis

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.

Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1 November 2004 for the provision of oral and maxillofacial surgery services and relevant attendances.

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 is 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 oral and maxillofacial services 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).

The referral must be from a registered dental practitioner or a medical practitioner.

OC.6 Assistance at Operations (Items 51800, 51803)

Items covering operations which are eligible for benefits for assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery or surgical assistance have been identified by the inclusion of the word "Assist" in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to an approved dental practitioner no additional benefits are payable. The assistance benefit is the same irrespective of the number of practitioners providing assistance.

Benefits payable under item 51800

Medicare benefits are payable under Item 51800 for assistance rendered at the following procedures:

51900, 51904, 52010, 52018, 52039, 52048, 52051, 52062, 52063, 52066, 52078, 52090, 52092, 52095, 52105, 52108, 52111, 52130, 52138, 52141, 52144, 52147, 52182, 52300, 52303, 52312, 52315, 52321, 52324, 52336, 52339, 52424, 52440, 52452, 52480, 52482, 52600, 52603, 52609, 52612, 52615, 52624, 52626, 52627, 52800, 52803, 52806, 52809, 52818, 52824, 52828, 52830, 53006, 53009, 53016, 53215, 53220, 53225, 53226, 53236, 53239, 53242, 53406, 53409, 53412, 53413, 53415, 53416, 53453, 53460.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under item 51300.

Benefits payable under Item 51803

51906, 52054, 52094, 52114, 52117, 52120, 52122, 52123, 52126, 52129, 52131, 52148, 52158, 52184, 52186, 52306, 52330, 52333, 52337, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52430, 52442, 52444, 52446, 52456, 52484, 52618, 52621, 52812, 52815, 52821, 52832, 53015, 53017, 53019, 53209, 53212, 53218, 53221, 53224, 53227, 53230, 53233, 53414, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53455.

or at a combination of procedures (including those identified as payable under item 51800 above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under Item 51303.

Assistance at multiple operations

Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Items 51800/51300 or 51803/51303).

The derived fee applicable to Item 51803/51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

OC.7 OPERATIONS (GROUPS 3 TO 9)

Repair of Wound (Item 51900)

Item 51900 covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

Lipectomy, Wedge Excision - Two or More Excisions (Item 51906)

Multiple lipectomies attract benefits under Item 51906 once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction.

Upper aerodigestive tract endoscopic procedures (Item 52035)

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

Cleaning, disinfection and sterilisation procedures

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

- (i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;
- (ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and
- (iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons. These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process (see paragraph 8.1 of the General Notes for Guidance).

Tumour, cyst, ulcer or scar (Items 52036 to 52054)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the surgical management of benign tumours.

Aspiration of haematoma (Item 52056)

Aspiration of haematoma is indicated in clinical situations where incision may leave an unsightly scar or where access is difficult for conventional drainage.

Osteotomy of Jaw (Items 52342 - 52375)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 52318 or 52319 for the harvesting, plus item 52130 or 52131 for the grafting.

For the purposes of these items, a reference to maxilla includes the zygoma.

Genioplasty (Item 52378)

Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

Fracture of Mandible or Maxilla (Items 53400 - 53439)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones. Hence a bilateral fracture of the mandible would be assessed as, say Item 53409 x 1½; two maxillae and one side of the mandible as Item 53406 x 1½ + 53409 x ¼.

Splinting in Item 53406 or 53409 refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

OC.8 Diagnostic Procedures and Investigations (Group 10)**Skin sensitivity testing (Item 53600)**

The allergens are local anaesthetics and the contents of anaesthetic capsules, acrylic and other polymers and metals.

OC.9 Regional or Field Nerve Blocks (Group 11)**Destruction of Nerve Branch by Neurolytic Agent (53706)**

T7.7.1 This item includes the use of botulinum toxin as a neurolytic agent.

GROUP 01 - CONSULTATIONS

APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY

‡ 51700	Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner, at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her <i>(See para OC.5 of explanatory notes to this Category)</i> Fee: \$77.25 Benefit: 75% = \$57.95 85% = \$65.70
‡ 51703	Professional attendance by an approved dental practitioner, each attendance subsequent to the first in a single course of treatment at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her <i>(See para OC.5 of explanatory notes to this Category)</i> Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
GROUP O3 - GENERAL SURGERY			
‡ 51900	WOUND OF SOFT TISSUE, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i>	Fee: \$294.45	Benefit: 75% = \$220.85 85% = \$250.30
‡ 51902	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 Groups O3 to O9 applies (Anaes.)	Fee: \$66.75	Benefit: 75% = \$50.10 85% = \$56.75
‡ 51904	LIPECTOMY - wedge excision of skin or fat - 1 EXCISION (Anaes.) (Assist.)	Fee: \$410.75	Benefit: 75% = \$308.10 85% = \$349.15
‡ 51906	LIPECTOMY - wedge excision of skin or fat - 2 OR MORE EXCISIONS (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i>	Fee: \$624.75	Benefit: 75% = \$468.60 85% = \$559.55
52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.)	Fee: \$74.50	Benefit: 75% = \$55.90 85% = \$63.35
52003	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.)	Fee: \$106.15	Benefit: 75% = \$79.65 85% = \$90.25
52006	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.)	Fee: \$106.15	Benefit: 75% = \$79.65 85% = \$90.25
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: \$167.65	Benefit: 75% = \$125.75 85% = \$142.55
52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	Fee: \$229.35	Benefit: 75% = \$172.05 85% = \$194.95
‡ 52012	SUPERFICIAL FOREIGN BODY, removal of, as an independent procedure (Anaes.)	Fee: \$21.20	Benefit: 75% = \$15.90 85% = \$18.05
‡ 52015	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and suture, as an independent procedure (Anaes.)	Fee: \$99.25	Benefit: 75% = \$74.45 85% = \$84.40
‡ 52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.)	Fee: \$249.95	Benefit: 75% = \$187.50 85% = \$212.50
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: \$26.60	Benefit: 75% = \$19.95 85% = \$22.65
‡ 52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (Anaes.)	Fee: \$47.15	Benefit: 75% = \$35.40 85% = \$40.10
52025	LYMPH NODE OF NECK, biopsy of (Anaes.)	Fee: \$166.05	Benefit: 75% = \$124.55 85% = \$141.15
‡ 52027	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure and not being a service to which item 52025 applies (Anaes.)	Fee: \$135.20	Benefit: 75% = \$101.40 85% = \$114.95
‡ 52030	SINUS, excision of, involving superficial tissue only (Anaes.)	Fee: \$81.25	Benefit: 75% = \$60.95 85% = \$69.10
‡ 52033	SINUS, excision of, involving muscle and deep tissue (Anaes.)	Fee: \$166.05	Benefit: 75% = \$124.55 85% = \$141.15

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
52034	PREALIGNANT LESIONS of the oral mucous, treatment by <u>cryotherapy, diathermy or carbon dioxide laser</u> Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00		
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: \$429.95 Benefit: 75% = \$322.50 85% = \$365.50		
‡ 52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), 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: \$114.60 Benefit: 75% = \$85.95 85% = \$97.45		
‡ 52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), 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: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30		
‡ 52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), 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: \$155.80 Benefit: 75% = \$116.85 85% = \$132.45		
‡ 52045	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$222.60 Benefit: 75% = \$166.95 85% = \$189.25		
‡ 52048	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$335.50 Benefit: 75% = \$251.65 85% = \$285.20		
‡ 52051	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$453.60 Benefit: 75% = \$340.20 85% = \$388.40		
‡ 52054	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$530.65 Benefit: 75% = \$398.00 85% = \$465.45		
‡ 52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS, not requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding after care) Fee: \$24.70 Benefit: 75% = \$18.55 85% = \$21.00		
‡ 52056	HAEMATOMA, aspiration of (Anaes.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$24.70 Benefit: 75% = \$18.55 85% = \$21.00		
‡ 52057	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) Fee: \$147.15 Benefit: 75% = \$110.40 85% = \$125.10		
‡ 52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS, using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$214.55 Benefit: 75% = \$160.95 85% = \$182.40		
‡ 52059	ABSCESS, DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$241.70 Benefit: 75% = \$181.30 85% = \$205.45		

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
‡ 52060	MUSCLE, excision of (Anaes.) Fee: \$171.05	Benefit: 75% = \$128.30	85% = \$145.40
‡ 52061	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) Fee: \$201.95	Benefit: 75% = \$151.50	85% = \$171.70
‡ 52062	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) Fee: \$267.00	Benefit: 75% = \$200.25	85% = \$226.95
‡ 52063	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) Fee: \$321.85	Benefit: 75% = \$241.40	85% = \$273.60
‡ 52064	BONE CYST, injection into or aspiration of (Anaes.) Fee: \$153.10	Benefit: 75% = \$114.85	85% = \$130.15
52066	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) Fee: \$402.25	Benefit: 75% = \$301.70	85% = \$341.95
52069	SUBLINGUAL GLAND, extirpation of (Anaes.) Fee: \$179.30	Benefit: 75% = \$134.50	85% = \$152.45
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) Fee: \$53.10	Benefit: 75% = \$39.85	85% = \$45.15
52073	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) Fee: \$135.20	Benefit: 75% = \$101.40	85% = \$114.95
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.) Fee: \$135.20	Benefit: 75% = \$101.40	85% = \$114.95
52078	TONGUE, partial excision of (Anaes.) (Assist.) Fee: \$267.00	Benefit: 75% = \$200.25	85% = \$226.95
52081	TONGUE TIE, division or excision of frenulum (Anaes.) Fee: \$42.00	Benefit: 75% = \$31.50	85% = \$35.70
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a person aged not less than 2 years (Anaes.) Fee: \$107.85	Benefit: 75% = \$80.90	85% = \$91.70
52087	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) Fee: \$184.85	Benefit: 75% = \$138.65	85% = \$157.15
52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) Fee: \$321.85	Benefit: 75% = \$241.40	85% = \$273.60
52092	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) Fee: \$419.50	Benefit: 75% = \$314.65	85% = \$356.60
‡ 52094	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 52092 (Anaes.) (Assist.) Fee: \$530.60	Benefit: 75% = \$397.95	85% = \$465.40
‡ 52095	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) Fee: \$343.85	Benefit: 75% = \$257.90	85% = \$292.30
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.) Fee: \$101.95	Benefit: 75% = \$76.50	85% = \$86.70
‡ 52097	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) Fee: \$144.55	Benefit: 75% = \$108.45	85% = \$122.90
‡ 52098	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) Fee: \$170.00	Benefit: 75% = \$127.50	85% = \$144.50

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL
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: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45	
‡ 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, per bone (Anaes.) Fee: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45	
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: \$238.05 Benefit: 75% = \$178.55 85% = \$202.35	
‡ 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 (Anaes.) Fee: \$98.35 Benefit: 75% = \$73.80 85% = \$83.60	
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.) Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30	
52111	VERMILIONECTOMY (Anaes.) (Assist.) Fee: \$294.45 Benefit: 75% = \$220.85 85% = \$250.30	
52114	MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) Fee: \$530.65 Benefit: 75% = \$398.00 85% = \$465.45	
52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes.) (Assist.) Fee: \$631.65 Benefit: 75% = \$473.75 85% = \$566.45	
+ 52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes.) (Assist.) Fee: \$747.10 Benefit: 75% = \$560.35 85% = \$681.90	
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: \$747.10 Benefit: 75% = \$560.35 85% = \$681.90	
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) Fee: \$845.80 Benefit: 75% = \$634.35 85% = \$780.60	
52126	MAXILLA, total resection of (Anaes.) (Assist.) Fee: \$813.15 Benefit: 75% = \$609.90 85% = \$747.95	
52129	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) Fee: \$1,088.55 Benefit: 75% = \$816.45 85% = \$1,023.35	
‡ 52130	BONE GRAFT, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) Fee: \$399.55 Benefit: 75% = \$299.70 85% = \$339.65	
‡ 52131	BONE GRAFT WITH INTERNAL FIXATION, not being a service to which an item in the range 51900 to 53070 or the range 53203 to 53460 applies (Anaes.) (Assist.) Fee: \$552.65 Benefit: 75% = \$414.50 85% = \$487.45	
+ 52132	TRACHEOSTOMY (Anaes.) Fee: \$224.80 Benefit: 75% = \$168.60 85% = \$191.10	
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) Fee: \$82.20 Benefit: 75% = \$61.65 85% = \$69.90	
‡ 52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.) Fee: \$130.35 Benefit: 75% = \$97.80 85% = \$110.80	
+ 52138	MAXILLARY ARTERY, ligation of (Anaes.) (Assist.) Fee: \$405.05 Benefit: 75% = \$303.80 85% = \$344.30	

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
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: \$400.70 Benefit: 75% = \$300.55 85% = \$340.60		
‡ 52144	FOREIGN BODY, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) Fee: \$373.45 Benefit: 75% = \$280.10 85% = \$317.45		
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) Fee: \$352.40 Benefit: 75% = \$264.30 85% = \$299.55		
52148	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) Fee: \$622.95 Benefit: 75% = \$467.25 85% = \$557.75		
52158	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) Fee: \$1,003.05 Benefit: 75% = \$752.30 85% = \$937.85		
	MALIGNANT DISEASE		
‡ 52180	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) Fee: \$170.00 Benefit: 75% = \$127.50 85% = \$144.50		
‡ 52182	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) Fee: \$374.15 Benefit: 75% = \$280.65 85% = \$318.05		
‡ 52184	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) Fee: \$552.65 Benefit: 75% = \$414.50 85% = \$487.45		
‡ 52186	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) Fee: \$680.25 Benefit: 75% = \$510.20 85% = \$615.05		

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
GROUP O4 - PLASTIC & RECONSTRUCTIVE			
‡ 52300	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.) Fee: \$256.80	Benefit: 75% = \$192.60	85% = \$218.30
‡ 52303	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with buccal pad of fat (Anaes.) (Assist.) Fee: \$366.70	Benefit: 75% = \$275.05	85% = \$311.70
‡ 52306	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) Fee: \$544.05	Benefit: 75% = \$408.05	85% = \$478.85
‡ 52309	FREE GRAFTING (mucosa or split skin) of a granulating area (Anaes.) Fee: \$184.85	Benefit: 75% = \$138.65	85% = \$157.15
‡ 52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Anaes.) (Assist.) Fee: \$256.80	Benefit: 75% = \$192.60	85% = \$218.30
‡ 52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (Anaes.) (Assist.) Fee: \$427.85	Benefit: 75% = \$320.90	85% = \$363.70
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: \$127.55	Benefit: 75% = \$95.70	85% = \$108.45
+ 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: \$212.65	Benefit: 75% = \$159.50	85% = \$180.80
‡ 52321	FOREIGN IMPLANT (NON-BIOLOGICAL), insertion of, for CONTOUR RECONSTRUCTION of pathological deformity, not being a service associated with a service to which item 52624 applies (Anaes.) (Assist.) Fee: \$427.85	Benefit: 75% = \$320.90	85% = \$363.70
52324	DIRECT FLAP REPAIR, using tongue, first stage (Anaes.) (Assist.) Fee: \$427.85	Benefit: 75% = \$320.90	85% = \$363.70
52327	DIRECT FLAP REPAIR, using tongue, second stage (Anaes.) Fee: \$212.25	Benefit: 75% = \$159.20	85% = \$180.45
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.) Fee: \$706.15	Benefit: 75% = \$529.65	85% = \$640.95
52333	CLEFT PALATE, primary repair (Anaes.) (Assist.) Fee: \$706.15	Benefit: 75% = \$529.65	85% = \$640.95
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.) Fee: \$441.40	Benefit: 75% = \$331.05	85% = \$376.20
52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) Fee: \$965.50	Benefit: 75% = \$724.15	85% = \$900.30
52339	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) Fee: \$502.65	Benefit: 75% = \$377.00	85% = \$437.45
52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para OC.7 of explanatory notes to this Category) Fee: \$873.05	Benefit: 75% = \$654.80	85% = \$807.85
52345	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para OC.7 of explanatory notes to this Category) Fee: \$984.65	Benefit: 75% = \$738.50	85% = \$919.45

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para OC.7 of explanatory notes to this Category) Fee: \$1,112.65 Benefit: 75% = \$834.50 85% = \$1,047.45		
52351	MANDIBLE or MAXILLA, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para OC.7 of explanatory notes to this Category) Fee: \$1,249.55 Benefit: 75% = \$937.20 85% = \$1,184.35		
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para OC.7 of explanatory notes to this Category) Fee: \$1,266.75 Benefit: 75% = \$950.10 85% = \$1,201.55		
52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para OC.7 of explanatory notes to this Category) Fee: \$1,426.15 Benefit: 75% = \$1,069.65 85% = \$1,360.95		
52360	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para OC.7 of explanatory notes to this Category) Fee: \$1,454.90 Benefit: 75% = \$1,091.20 85% = \$1,389.70		
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.) (See para OC.7 of explanatory notes to this Category) Fee: \$1,636.75 Benefit: 75% = \$1,227.60 85% = \$1,571.55		
52366	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para OC.7 of explanatory notes to this Category) Fee: \$1,600.55 Benefit: 75% = \$1,200.45 85% = \$1,535.35		
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: \$1,799.55 Benefit: 75% = \$1,349.70 85% = \$1,734.35		
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: \$1,746.15 Benefit: 75% = \$1,309.65 85% = \$1,680.95		
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: \$1,955.85 Benefit: 75% = \$1,466.90 85% = \$1,890.65		
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: \$676.10 Benefit: 75% = \$507.10 85% = \$610.90		
+ 52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.) (Assist.) Fee: \$1,155.45 Benefit: 75% = \$866.60 85% = \$1,090.25		
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: \$1,967.50 Benefit: 75% = \$1,475.65 85% = \$1,902.30		

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL
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: \$2,358.45 Benefit: 75% = \$1,768.85 85% = \$2,293.25	
52420	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity Fee: \$217.80 Benefit: 75% = \$163.35 85% = \$185.15	
‡ 52424	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) Fee: \$427.75 Benefit: 75% = \$320.85 85% = \$363.60	
‡ 52430	MICROVASCULAR REPAIR OF, using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) Fee: \$984.65 Benefit: 75% = \$738.50 85% = \$919.45	
52440	CLEFT LIP, unilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$488.90 Benefit: 75% = \$366.70 85% = \$423.70	
52442	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$611.25 Benefit: 75% = \$458.45 85% = \$546.05	
52444	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$679.00 Benefit: 75% = \$509.25 85% = \$613.80	
52446	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$801.45 Benefit: 75% = \$601.10 85% = \$736.25	
52450	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) Fee: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90	
52452	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) Fee: \$441.40 Benefit: 75% = \$331.05 85% = \$376.20	
52456	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) Fee: \$747.10 Benefit: 75% = \$560.35 85% = \$681.90	
52458	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) Fee: \$271.60 Benefit: 75% = \$203.70 85% = \$230.90	
52460	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) Fee: \$706.15 Benefit: 75% = \$529.65 85% = \$640.95	
52480	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.) Fee: \$453.60 Benefit: 75% = \$340.20 85% = \$388.40	
52482	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) Fee: \$436.45 Benefit: 75% = \$327.35 85% = \$371.25	
52484	MACROSTOMIA, operation for (Anaes.) (Assist.) Fee: \$519.55 Benefit: 75% = \$389.70 85% = \$454.35	

ORAL & MAXILLOFACIAL	ORAL & MAXILLOFACIAL
GROUP O5 - PREPROSTHETIC	
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) Fee: \$305.55 Benefit: 75% = \$229.20 85% = \$259.75
52603	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) Fee: \$292.10 Benefit: 75% = \$219.10 85% = \$248.30
52606	MAXILLARY TUBEROSITY, reduction of (Anaes.) Fee: \$222.80 Benefit: 75% = \$167.10 85% = \$189.40
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) Fee: \$292.10 Benefit: 75% = \$219.10 85% = \$248.30
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) Fee: \$366.70 Benefit: 75% = \$275.05 85% = \$311.70
52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) Fee: \$455.05 Benefit: 75% = \$341.30 85% = \$389.85
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) Fee: \$529.60 Benefit: 75% = \$397.20 85% = \$464.40
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) Fee: \$529.60 Benefit: 75% = \$397.20 85% = \$464.40
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) Fee: \$427.75 Benefit: 75% = \$320.85 85% = \$363.60
52626	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) Fee: \$262.35 Benefit: 75% = \$196.80 85% = \$223.00
52627	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.) Fee: \$455.05 Benefit: 75% = \$341.30 85% = \$389.85
52630	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.) Fee: \$168.45 Benefit: 75% = \$126.35 85% = \$143.20
52633	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) Fee: \$455.05 Benefit: 75% = \$341.30 85% = \$389.85
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: \$168.45 Benefit: 75% = \$126.35 85% = \$143.20

GROUP O6 - NEUROSURGICAL

‡ 52800	NEUROLYSIS BY OPEN OPERATION, without transposition, not being a service associated with a service to which item 52803 applies (Anaes.) (Assist.) Fee: \$249.95 Benefit: 75% = \$187.50 85% = \$212.50
‡ 52803	NERVE TRUNK, internal (interfascicular), NEUROLYSIS of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$359.90 Benefit: 75% = \$269.95 85% = \$305.95
‡ 52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (Anaes.) (Assist.) Fee: \$249.95 Benefit: 75% = \$187.50 85% = \$212.50
‡ 52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve (Anaes.) (Assist.) Fee: \$427.85 Benefit: 75% = \$320.90 85% = \$363.70
‡ 52812	NERVE TRUNK, PRIMARY repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$611.25 Benefit: 75% = \$458.45 85% = \$546.05
‡ 52815	NERVE TRUNK, SECONDARY repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$645.10 Benefit: 75% = \$483.85 85% = \$579.90
‡ 52818	NERVE, TRANSPOSITION OF (Anaes.) (Assist.) Fee: \$427.85 Benefit: 75% = \$320.90 85% = \$363.70
‡ 52821	NERVE GRAFT TO NERVE TRUNK, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) Fee: \$930.35 Benefit: 75% = \$697.80 85% = \$865.15
52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) Fee: \$400.70 Benefit: 75% = \$300.55 85% = \$340.60
52826	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) Fee: \$214.55 Benefit: 75% = \$160.95 85% = \$182.40
‡ 52828	CUTANEOUS NERVE, primary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$319.10 Benefit: 75% = \$239.35 85% = \$271.25
‡ 52830	CUTANEOUS NERVE, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$420.90 Benefit: 75% = \$315.70 85% = \$357.80
‡ 52832	CUTANEOUS NERVE, nerve graft to, using microsurgical techniques (Anaes.) (Assist.) Fee: \$577.25 Benefit: 75% = \$432.95 85% = \$512.05

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
GROUP O7 - EAR, NOSE & THROAT			
53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) Fee: \$29.35	Benefit: 75% = \$22.05	85% = \$24.95
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: \$83.05	Benefit: 75% = \$62.30	85% = \$70.60
+ 53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes.) Fee: \$32.15	Benefit: 75% = \$24.15	85% = \$27.35
53006	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) Fee: \$470.70	Benefit: 75% = \$353.05	85% = \$405.50
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) Fee: \$267.00	Benefit: 75% = \$200.25	85% = \$226.95
53012	ANTRUM, drainage of, through tooth socket (Anaes.) Fee: \$106.15	Benefit: 75% = \$79.65	85% = \$90.25
53015	ORO-ANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) Fee: \$530.65	Benefit: 75% = \$398.00	85% = \$465.45
53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.) Fee: \$436.45	Benefit: 75% = \$327.35	85% = \$371.25
53017	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) Fee: \$544.45	Benefit: 75% = \$408.35	85% = \$479.25
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) Fee: \$524.55	Benefit: 75% = \$393.45	85% = \$459.35
53052	POST-NASAL SPACE, direct examination of, with or without biopsy (Anaes.) Fee: \$110.95	Benefit: 75% = \$83.25	85% = \$94.35
+ 53054	NASENOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.) Fee: \$110.95	Benefit: 75% = \$83.25	85% = \$94.35
53056	EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$64.95	Benefit: 75% = \$48.75	85% = \$55.25
+ 53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) Fee: \$110.95	Benefit: 75% = \$83.25	85% = \$94.35
53060	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES FOR OBSTRUCTION OR HAEMORRHAGE SECONDARY TO SURGERY (OR TRAUMA) - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) Fee: \$90.75	Benefit: 75% = \$68.10	85% = \$77.15
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) Fee: \$81.25	Benefit: 75% = \$60.95	85% = \$69.10
53064	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) Fee: \$147.15	Benefit: 75% = \$110.40	85% = \$125.10
+ 53068	TURBINECTOMY or TURBINECTOMIES, partial or total, unilateral (Anaes.) Fee: \$123.25	Benefit: 75% = \$92.45	85% = \$104.80

ORAL & MAXILLOFACIAL**ORAL & MAXILLOFACIAL**

53070	TURBINATES, submucous resection of, unilateral (Anaes.) Fee: \$160.75 Benefit: 75% = \$120.60 85% = \$136.65
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ORAL & MAXILLOFACIAL**ORAL & MAXILLOFACIAL**

53242	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) Fee: \$282.05 Benefit: 75% = \$211.55 85% = \$239.75
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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: \$116.65 Benefit: 75% = \$87.50 85% = \$99.20
53403	MANDIBLE, treatment of fracture of, not requiring splinting <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$142.50 Benefit: 75% = \$106.90 85% = \$121.15
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: \$367.25 Benefit: 75% = \$275.45 85% = \$312.20
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: \$367.25 Benefit: 75% = \$275.45 85% = \$312.20
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$77.35 Benefit: 75% = \$58.05 85% = \$65.75
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: \$215.70 Benefit: 75% = \$161.80 85% = \$183.35
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: \$354.10 Benefit: 75% = \$265.60 85% = \$301.00
+ 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: \$433.80 Benefit: 75% = \$325.35 85% = \$368.75
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: \$498.35 Benefit: 75% = \$373.80 85% = \$433.15
53415	MAXILLA, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$393.45 Benefit: 75% = \$295.10 85% = \$334.45
53416	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$393.45 Benefit: 75% = \$295.10 85% = \$334.45
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: \$511.45 Benefit: 75% = \$383.60 85% = \$446.25
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: \$511.45 Benefit: 75% = \$383.60 85% = \$446.25
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: \$649.05 Benefit: 75% = \$486.80 85% = \$583.85
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: \$649.05 Benefit: 75% = \$486.80 85% = \$583.85

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: \$556.90	Benefit: 75% = \$417.70 85% = \$491.70
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: \$556.90	Benefit: 75% = \$417.70 85% = \$491.70
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: \$760.60	Benefit: 75% = \$570.45 85% = \$695.40
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: \$760.60	Benefit: 75% = \$570.45 85% = \$695.40
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) (See para OC.7 of explanatory notes to this Category)	Fee: \$215.70	Benefit: 75% = \$161.80 85% = \$183.35
53453	ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.)	Fee: \$436.45	Benefit: 75% = \$327.35 85% = \$371.25
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.)	Fee: \$512.65	Benefit: 75% = \$384.50 85% = \$447.45
53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies	Fee: \$38.85	Benefit: 75% = \$29.15 85% = \$33.05
53459	NASAL BONES, treatment of fracture of, by reduction (Anaes.)	Fee: \$212.65	Benefit: 75% = \$159.50 85% = \$180.80
53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.)	Fee: \$433.80	Benefit: 75% = \$325.35 85% = \$368.75

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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 <i>(See para OC.7 of explanatory notes to this Category)</i> Fee: \$35.15 Benefit: 75% = \$26.40 85% = \$29.90
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GROUP 011 - REGIONAL OR FIELD NERVE BLOCKS

	(Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.))	
53700	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent Fee: \$56.45	Benefit: 75% = \$42.35 85% = \$48.00
53704	FACIAL NERVE, injection of an anaesthetic agent Fee: \$34.00	Benefit: 75% = \$25.50 85% = \$28.90
‡ 53706	NERVE BRANCH, 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: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85

Ic ProceduresA

Abscess	
- deep, percutaneous drainage	52058
- drainage tube, exchange of	52059
- incision with drainage, requiring admission	52055
- large, incision with drainage, requiring admission	52057
Alveolar ridge augmentation	52624, 52626
- cleft grafting of	52337
Antrobuccal fistula operation	53015
Antrostomy, radical	53006
Antrum	
- drainage of, through tooth socket	53012
- intranasal operation, or removal of foreign body	53009
- maxillary, proof puncture and lavage of	53000, 53003
- maxillary, removal of foreign body from	53009
Arch bars, to maxilla or mandible, removal of	52106
Artery, facial, mandibular or lingual, ligation of	52141
- maxillary, ligation of	52138
Arthrocentesis, with irrigation of temporomandibular joint	53225
Antroscopy of temporomandibular joint	53215, 53218
Aspiration biopsy, one or more jaw cysts	52021
Assistance at operation	51800, 51803
Attendance	51700, 51703
Axillary sinus, excision of	52033

B

Basal cell carcinoma	
- complicated , removal	52051, 52054
- uncomplicated, removal	52036-52048
Biopsy, aspiration of jaw cysts	52021
- lymph gland, muscle or other deep tissue or organ	52027
- skin or mucous membrane	52024
Bone	
- cyst, injection into or aspiration of	52064
- graft, harvesting of, via separate incision	52318,52319
- graft, to other bones	52130
- graft, with internal fixation	52131
- growth stimulator	52095
- tumour, malignant, operations for	52180-52186

C

Calculus, removal of, salivary gland duct	52075
Caldwell-Luc's operation	53006
Carbuncle, incision with drainage, in operating theatre	52057
Cauterisation, septum/turbinates/pharynx	53060

Cellulitis, incision with drainage, in operating theatre	52057
- incision with drainage, not requiring GA	52055
Cleft lip, operations for	52440-52458
Cleft palate, primary repair	52333
- palate, secondary repair, closure of fistula	52336
- palate, secondary repair, lengthening procedure	52339
Composite graft to nose, ear or eyelid	52482
Condylectomy/condylotomy	53224
Contour reconstruction, insertion of foreign implants	52321
Cricothyrostomy	52133
Cutaneous nerve, nerve graft to	52832
- repair of	52828, 52830
Cyst, jaw, aspiration biopsy of	52021
- mandible or maxilla, segmental resection of	52114
- not otherwise covered, removal of	52036-52048

D

Deep tissue or organ, biopsy of	52027
Dermis, dermofat or fascia graft	52424
Dermoid, excision	52036-52045
Diathermy, salivary gland duct	52072
Dilatation, salivary gland duct	52072
Dislocation, mandible, treatment of	53200-53203
Duct, salivary gland, diathermy or dilatation of	52072
- salivary gland, removal of calculus from	52075
- sublingual gland, removal of calculus from	52075

E

Endo-biopsy	52024,52027
Endoscopic, laser therapy of upper aerodigestive tract	52035
Exostosis, mandibular or palatal, excision of	52600
External fixation, orthopaedic, removal	52097,52098

F

Face, contour reconstruction	52379
Facial artery or vein, ligation of	52141
Fibroma, removal of	52036-52045
Fistula, antrobuccal, operation for	53015
- oro-antral, plastic closure of	53015
Flap repair, direct	52324,52327
- repair, single stage local	52300-52306
Foreign body, antrum, removal of	53009
- body, deep, removal, interventional imaging	52144
- body, maxillary sinus, removal of	53009
- body, muscle/other deep tissue, removal of	52018
- body, subcutaneous, removal, other	52015

- body, superficial removal, other	52012
- body, tendon, removal of	52018,52144
- implants for contour reconstruction, insertion of	52321
Fracture, mandible or maxilla, treatment of	53400-53439
- zygomatic bone, treatment of	53411-53414
Free grafts, full thickness	52315
- grafts, mucosa/split skin/connective tissue	52309,52312
Frenulum, mandibular or maxillary, repair of	52084
Furuncle, incision with drainage, in operating theatre	52057

G

Genioplasty	52378
Gland, lumph, biopsy of	52027
- salivary, dilatation or diathermy of duct	52072
- salivary, incision of	52057
- salivary, meatotomy or marsupialisation	52075
- salivary, removal of calculus from duct	52075
- salivary, transposition of duct	52147
- sublingual, extirpation of	52069
- submandibular, extirpation of	52066
- submaxillary, extirpation of	52066
- submaxillary, incision of	52057,52147
Glenoid fossa, zygomatic arch, temporal bone, reconstruction	53209
Grafts, compsite (chondrocutaneous/mucosal)	52480
- free, full thickness	52315
- mucosa or split skin	52309,52312

H

Haematoma, aspiration of	52056
- incision with drainage, not requiring GA	52055
- large, incision with drainage, in operating theatre	52057
Haemorrhage, post-nasal and/or post-operative, control of	52135
Hemifacial microsomia, construction condyle and ramus	53212
Hyperplasia, papillary, of palate, removal of	52609-52615
Hypertrophied tissue, removal of	52036-52045

I

Innocent bone tumour, excision of	52063
Intranasal operation on antrum/removal foreign body	53009

J

Jaw, aspiration biopsy of cyst/s	52021
- dislocation, treatment of	53200,53203

- fracture, treatment of	53400-53439
- operation on, for osteomyelitis	52090
- plastic and reconstructive operation on	52342-52375

K

Keloid, excision of	52036-52045
Kirschner wire, insertion of	52096

L

Lacerations	
- ear/eyelid/nose/lip, full thickness, repair of	52010
- repair and suturing of	52000-52009
Lavage and proof puncture of maxillary antrum	53000,53003
Le Fort osteotomies	52380,52382
Lingual artery or vein, ligation of	52141
Lip, full thickness wedge excision of	52108
Lipectomy, wedge excision	51904,51906
Lipoma, removal of	52036-52045
Local flap repair, single stage	52300-52306
Lymph gland, muscle or other deep tissue or organ biopsy of	52027
Lymph node, biopsy of	52025
Lymphoid patches, removal of	52036-52045

M

Macrocheilia, operation for	52482
Macrostomia, operation for	52484
Mandible, dislocation, treatment of	53200,53203
- fixation by intermaxillary wiring	52420
- hemi-mandiblectomy of	52120
- hemi-mandibular reconstruction with bone graft	52122
- operation on, for osteomyelitis	52090
- or maxilla, fractures, treatment of	53400-53439
- osteectomy of osteotomy of	53400-53439
- removal of one or more plates	52342-52375
- removal of buried wire, pin or screw	52099, 52102
- segmental resection of, for tumours or cysts	52114
- sub-total resection of	52117
- total resection of	52123
Mandibular artery or vein, ligation of	52141
- exostosis, excision of	52600
- frenulum, repair of	52084
Maxilla, operation on, for osteomyelitis	52090
- or mandible, fractures, treatment of	53400-53439
- osteectomy or osteotomy of	52342-52375
- removal of buried wire, pin or screw	52099, 52102
- removal of one or more plates	52105
- sub-total resection of	52117
- total resection of	52126, 52129
Maxillary antrum, lavage of	53004
- proof puncture and lavage of	53000, 53003
- artery, ligation of	52138
- frenulum, repair of	52084

- sinus, drainage of, through tooth socket 53012
 - sinus, operations on 53006, 53009
 - sinus, sinus lift procedure 53019
 - tuberosity, reduction of 52606
 Melanoma, excision of 52036-52048
 Micro-arterial graft 52434
 Microvascular anastomosis using microsurgical techniques 52430
 - repair using microsurgical techniques 52424
 Mouth, lowering of floor of (Obwegeser or similar) 52621
 Mucous membrane, biopsy of 52024
 - membrane, repair of recent wound of 52000-52009
 Muscle, biopsy of 52027
 - excision of 52060
 - or other deep tissue, removal of foreign body 52018
 - ruptured, repair of 52061, 52062
 Mylohyoid ridge, reduction of 52603

N

Naevus, excision of 52036-52045
 Nasal bones, treatment of fracture/s 53458-53460
 Nasal cavity and/or post nasal space examination of 53056
 - cavity, packing for arrest of haemorrhage 53062
 - haemorrhage, arrest of 53058
 - haemorrhage, cryotherapy to 53064
 - space, post, direct examination of 53052
 Nasal septum, reconstruction 53017
 Nasal septum, septoplasty 53016
 Nasendoscopy 53054
 Nerve, clock, regional or field 53700-53704
 - peripheral, neurectomy/neurotomy/tumour 52806, 52809
 - transposition of 52818
 - trigeminal, cryosurgery of 52824
 - trunk, graft to 52821
 - trunk, neurolysis of 52803
 - trunk, repair of 52812-52815
 Neurolysis by open operation 52800
 - of nerve trunk 52803
 Neurectomy, peripheral nerve 52806, 52809
 Node, lymph, biopsy of 52027

O

Orbital cavity, bone or cartilage graft to, wall or floor 53455
 - cavity, reconstruction of wall or floor 53453
 Oro-antral fistula, plastic closure of 53015
 Orthopaedic pin or wire, insertion of 52096
 - pin or wire, removal of 52099, 52102
 - plates, removal of 52105
 Osseointegration procedure 52627-52636
 Osteotomy of mandible or maxilla 52342-52375
 Osteomyelitis, operation on mandible or maxilla 52090

- operation on skull 52092
 - operation on combination of adjoining bones 52094
 Osteotomies, mid-facial 52380, 52382
 Osteotomy of mandible or maxilla 52342-52375
 Palatal exostosis, excision of 52600
 Palate, cleft, repair of 52333, 52336, 52339
 - papillary hyperplasia removal of 52609,-52615
 - plastic closure of defect of 52330
 Papillary hyperplasia of the palate, removal of 52609-52615
 Papilloma, removal or 52036-52045
 Parotid duct, repair of 52148
 Pharyngeal flap for velo-pharyngeal incompetence 52460
 Pin, orthopaedic, insertion of 52096
 - orthopaedic, removal of 52099, 52102
 Plastic repair, free grafts 52309-52315
 - repair, single stage, local flap 52300-52306
 Plates, orthopaedic, removal of 52015, 52018
 Post nasal space, examination under GA 53056
 - direct examination of with/without biopsy 53052
 Premalignant lesions, cryotherapy, diathermy or carbon dioxide laser 52034
 Preauricular sinus operations 52030
 Proof puncture of maxillary antrum 53000, 53003

R

Radical antrostomy 53006
 Ranula, removal of 52087
 Reduction of dislocation of mandible 53200, 53203
 Rodent ulcer, operation for 52036-52045

S

Salivary gland duct, diathermy or dilatation of 52072
 - gland duct, removal of calculus from 52075
 - gland duct, transposition of 52147
 - gland, incision of 52057
 - gland, repair of cutaneous fistula of 52073
 Scar, removal of, not otherwise covered 52036-52045
 Sebaceous cyst, removal of 52036-52045
 Segmental resection of mandible or maxilla for tumours 52114
 Single stage local flap repair 52300-52306
 Sinus, excision of 52030, 52033
 - maxillary, drainage of, through tooth socket 53012
 Skin biopsy of 52024
 - repair of recent wound 52000-52009
 - sensitivity testing 53600
 Skull, operation on, for osteomyelitis 52092
 Subcutaneous foreign body, removal, other 52015
 - tissue, repair of recent wound 52000-52009
 Sublingual gland duct, removal or calculus from 52075

- gland, extirpation of	52069
Submandibular abscess, incision of	52057
- ducts, relocation of	52158
- gland, extirpation of	52066
- gland, incision of	52057
Submaxillary gland, extirpation of	52066
- gland, incision of	52057
Superficial foreign body, removal of	52012
- wound repair of	52000, 52009
Suture of traumatic wounds	52000-52009

T

Temporal bone glenoid fossa/zygomatic arch, reconstruction of	53209
Temporomandibular joint	
- arthrodesis	53239
- arthrotomy	53220
- arthroscopy of	53215, 53218
- joint, external fixation, application of	53242
- joint, irrigation of	53225
- joint, manipulation of	53206
- stabilisation of	53236
- synovectomy of	53226
- joint, open surgical exploration of	53221-53233
Tendon, foreign body in, removal of	52018
- or other deep tissue, foreign body in, removal of	52018
Tissue, subcutaneous, repair or recent wound	52000-52009
Tongue, partial excision of	52078
- tie, repair of	52081, 52084
Tracheostomy	52132
Traumatic wounds, repair of	52000-52009
Trigeminal nerve, injection with alcohol, cortisone, etc	52826
Tuberosity, maxillary, reduction of	52606
Tumour, bone, innocent, excision of	52063
- mandible or maxilla, segmental resection of	52114
- not otherwise covered, removal of	52036 - 52048
- peripheral nerve, removal of	52806, 52809
- soft tissue, excision of	52051, 52054
Turbinates	
- submucous resection of	53070
Turbineotomy, partial or total	53018

V

Vein, facial, mandibular or lingual, ligation of	52141
Vermilionectomy	52111
Vestibuloplasty, unilateral or bilateral	52618

W

Washout, antrum	53000-53003
Wire, orthopaedic, insertion of	52096
- orthopaedic, removal of	52099, 52102
Wound	
- debridement under GA or major block	51900
- dressing of, requiring GA	51902
- traumatic, suture of	52000-52009

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:

55836, 55840, 55844, 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

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.

Dating of pregnancy

When dating a pregnancy for the purpose of items 55700 to 55774, a patient is:

- a) "less than 12 weeks of gestation" means up to 11 weeks and 6 days of pregnancy;
- b) "12 to 16 weeks of gestation" means from 12 weeks 0 days of pregnancy up to 16 weeks plus 6 days of pregnancy (inclusive);
- c) "17 to 22 weeks of gestation" means from 17 weeks 0 days of pregnancy up to 22 weeks plus 6 days of pregnancy (inclusive); or
- d) "after 22 weeks of gestation" means from 23 weeks 0 days of pregnancy onwards
- e) "after 24 weeks of gestation" means from 25 weeks 0 days of pregnancy onwards.

Nuchal Translucency Testing

Where a nuchal translucency measurement is performed when the pregnancy is dated by a crown rump length of 45-84mm 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 foetal 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.

Multiple Musculoskeletal Ultrasound Scans - items 55800 to 55846

Generally Medicare benefits are payable for more than one musculoskeletal ultrasound scan performed on the same day, however the scans are subject to Rule A of the general diagnostic imaging multiple services rules.

It is not permitted to split a bilateral scan. Where bilateral ultrasound scans are performed (or more than one area is scanned under items 55844 or 55646) the relevant item should be itemised once only on accounts and receipts or Medicare bulk billing forms. For example if both shoulders are scanned, Item 55808 (or 55810 as the case may be) should be claimed once only. This is because the item descriptor for these items covers one or both sides, or one or more areas.

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). CT Colonography is covered by items 56552 and 56554.

Computed Tomography of the Colon (Items 56552 and 56554)

In items 56552 and 56554 the terms 'high risk' and 'incomplete colonoscopy' are defined as follows:

High Risk

Asymptomatic people fit into this category if they have:

- three or more first-degree or a combination of first-degree and second-degree relatives on the same side of the family diagnosed with bowel cancer (suspected hereditary non-polyposis colorectal cancer or NPCC), or
- two or more first-degree or second-degree relatives on the same side of the family diagnosed with bowel cancer, including any of the following high-risk features:
 - multiple bowel cancers in the one person
 - bowel cancer before the age of 50 years
 - at least one relative with cancer of the endometrium, ovary, stomach, small bowel, ureter, biliary tract or brain
- at least one first-degree relative with a large number of adenomas throughout the large bowel (suspected familial adenomatous polyposis or FAP), or
- somebody in the family in whom the presence of a high-risk mutation in the adenomatous polyposis coli (APC) gene or one of the mismatch repair (MMR) genes has been identified.

Source: NHMRC 2005 Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer - Category 3 — those at potentially high risk.

www.nhmrc.gov.au/publications/synopses/cp106syn.htm.

Incomplete Colonoscopy

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.

Credentiailling for nuclear medicine imaging services

Payment of Medicare rebates for nuclear medicine imaging services is limited to specialists or consultant physicians who are credentiailled by the Joint Nuclear Medicine Credentiailling 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 myocardialperfusion studies (Items 61302 and 61303)

Items 61302 and 61303 apply to single myocardial perfusion studies which can only be used once and cannot be used in conjunction with any other myocardial perfusion study for an individual patient referral.

Myocardialperfusion (Items 61306 and 61307)

Items 61306 and 61307 refer to all myocardial perfusion studies involving two or more sets of imaging times related to an individual patient referral. This includes stress/rest, stress/re-injection, stress/rest and re-injection thallium studies, one or two-day technetium-based perfusion agent protocols, mixed technetium-based perfusion agent/thallium protocols and the use of gated SPECT when undertaken.

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.
- (e) equipment at locations described in rule 36(d) - *eligible equipment*, of the Health Insurance (Diagnostic Imaging Services Table) Regulations as in force on 1 November 2007.

The location of Medicare-eligible MRI machines is available at the Department of Health and Ageing's website at <http://www.health.gov.au/>

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>	Fee: \$109.10	Benefit: 75% = \$81.85 85% = \$92.75
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>	Fee: \$37.85	Benefit: 75% = \$28.40 85% = \$32.20
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>	Fee: \$109.10	Benefit: 75% = \$81.85 85% = \$92.75
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>	Fee: \$37.85	Benefit: 75% = \$28.40 85% = \$32.20
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>	Fee: \$109.10	Benefit: 75% = \$81.85 85% = \$92.75
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>	Fee: \$37.85	Benefit: 75% = \$28.40 85% = \$32.20
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>	Fee: \$111.30	Benefit: 75% = \$83.50 85% = \$94.65
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>	Fee: \$37.85	Benefit: 75% = \$28.40 85% = \$32.20
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>	Fee: \$109.10	Benefit: 75% = \$81.85 85% = \$92.75
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>	Fee: \$37.85	Benefit: 75% = \$28.40 85% = \$32.20

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: \$230.65 Benefit: 75% = \$173.00 85% = \$196.10</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: \$230.65 Benefit: 75% = \$173.00 85% = \$196.10</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: \$230.65 Benefit: 75% = \$173.00 85% = \$196.10</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: \$261.65 Benefit: 75% = \$196.25 85% = \$222.45</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: \$261.65 Benefit: 75% = \$196.25 85% = \$222.45</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> <p>(a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations;</p> <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> <p>(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:</p> <p>(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:</p> <p>(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> <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> <p>(a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that:</p> <p>(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:</p> <p>(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> <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) toxaemia of pregnancy;
 - (v) liver or renal disease;
 - (vi) autoimmune disease;
 - (vii) cardiac disease;
 - (viii) alloimmunisation;
 - (ix) maternal infection;
 - (x) inflammatory bowel disease;
 - (xi) bowel stoma;
 - (xii) abdominal wall scarring;
 - (xiii) previous spinal or pelvic trauma or disease;
 - (xiv) drug dependency;
 - (xv) thrombophilia;
 - (xvi) significant maternal obesity;
 - (xvii) advanced maternal age;
 - (xviii) abdominal pain or mass;
 - (xix) uncertain dates;
 - (xx) high risk pregnancy;
 - (xxi) previous post dates delivery;
 - (xxii) previous caesarean section;
 - (xxiii) poor obstetric history;
 - (xxiv) suspicion of ectopic pregnancy;
 - (xxv) risk of miscarriage;
 - (xxvi) diminished symptoms of pregnancy;
 - (xxvii) suspected or known cervical incompetence;
 - (xxviii) suspected or known uterine abnormality;
 - (xxix) pregnancy after assisted reproduction;
 - (xxx) risk of fetal abnormality (R)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, 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 84mm, 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) toxoemia 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 84mm, 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

ULTRASOUND

OBSTETRIC AND GYNAECOLOGICAL

<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 84mm, 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 84mm; 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> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; 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) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 are present; and</p> <p>(e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and</p> <p>(f) the service is not performed in conjunction with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (NR)</p> <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> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 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 service is not performed in the same pregnancy as item 55706 (NR)</p> <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> <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 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</p> <p>(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 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 55706 or 55709 applies (R)</p> <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> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 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) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (NR)</p> <p>Fee: \$40.00 Benefit: 75% = \$30.00 85% = \$34.00</p>

ULTRASOUND	OBSTETRIC AND GYNAECOLOGICAL
55731	<p>PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(d) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R)</p> <p>Fee: \$98.00 Benefit: 75% = \$73.50 85% = \$83.30</p>
55733	<p>PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where:</p> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR)</p> <p>Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75</p>
55736	<p>PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and</p> <p>(d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R)</p> <p>Fee: \$127.00 Benefit: 75% = \$95.25 85% = \$107.95</p>
55739	<p>PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:</p> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR)</p> <p>Fee: \$57.00 Benefit: 75% = \$42.75 85% = \$48.45</p>
55759	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and</p> <p>(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and</p> <p>(d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and</p> <p>(f) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55762 during the same pregnancy (R)</p> <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> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and</p> <p>(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and</p> <p>(d) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55759 during the same pregnancy; and</p> <p>(e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR)</p> <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> <p>(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</p> <p>(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and</p> <p>(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and</p> <p>(d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and</p> <p>(f) further examination is clinically indicated in the same pregnancy to which item 55759 or 55762 has been performed; and</p> <p>(g) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (R)</p> <p>Fee: \$160.00 Benefit: 75% = \$120.00 85% = \$136.00</p>

ULTRASOUND

MUSCULOSKELETAL

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, supraspinatus, 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, supraspinatus, 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	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	
56227	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
56228	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
56229	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$122.50 Benefit: 75% = \$91.90 85% = \$104.15	
56230	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium, and with any scans to the 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	
56231	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$177.45 Benefit: 75% = \$133.10 85% = \$150.85	
56232	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) Fee: \$177.45 Benefit: 75% = \$133.10 85% = \$150.85	
56233	<i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i> 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	
56234	<i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i> 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	
56235	<i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i> 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	
56236	<i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i> 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	
56237	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) Fee: \$240.00 Benefit: 75% = \$180.00 85% = \$204.00	

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% = \$414.85	
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	
† 56552	COMPUTED TOMOGRAPHY OF COLON for exclusion of colorectal neoplasia in symptomatic or high risk patients if: (a) the patient has had an incomplete colonoscopy in the 3 months before the scan; and (b) the date of incomplete colonoscopy is set out on the request for scan; and (c) the service is not a service to which items 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.) <i>(See para DIL of explanatory notes to this Category)</i> Fee: \$600.00 Benefit: 75% = \$450.00 85% = \$534.80	
† 56554	COMPUTED TOMOGRAPHY OF COLON for exclusion of colorectal neoplasia in symptomatic or high risk patients if: (a) the request for scan states that one of the following contraindications to colonoscopy is present: (i) suspected perforation of the colon; (ii) complete or high-grade obstruction that will not allow passage of the scope; and (b) the service must not be a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.) <i>(See para DIL of explanatory notes to this Category)</i> Fee: \$600.00 Benefit: 75% = \$450.00 85% = \$534.80	
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% = \$401.35	
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% = \$494.80	
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% = \$401.45	
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% = \$502.55	
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% = \$404.80	

COMPUTED TOMOGRAPHY	COMPUTED TOMOGRAPHY
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>
57350	<p style="text-align: center;">SPIRAL ANGIOGRAPHY</p> <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: (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.) Fee: \$510.00 Benefit: 75% = \$382.50 85% = \$444.80</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: (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.) Fee: \$510.00 Benefit: 75% = \$382.50 85% = \$444.80</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: (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.) 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: 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.) 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 (perthrochanteric) 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		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% = \$498.80
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% = \$761.90
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% = \$1,110.90
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% = \$1,311.10
60012	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 1 to 3 data acquisition runs (R) (Anaes.) Fee: \$564.00 Benefit: 75% = \$423.00 85% = \$498.80
60015	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 4 to 6 data acquisition runs (R) (Anaes.) Fee: \$827.10 Benefit: 75% = \$620.35 85% = \$761.90
60018	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 7 to 9 data acquisition runs (R) (Anaes.) Fee: \$1,176.10 Benefit: 75% = \$882.10 85% = \$1,110.90
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% = \$1,311.10

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% = \$498.80		
60027	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 4 to 6 data acquisition runs (R) (Anaes.) Fee: \$827.10 Benefit: 75% = \$620.35 85% = \$761.90		
60030	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 7 to 9 data acquisition runs (R) (Anaes.) Fee: \$1,176.10 Benefit: 75% = \$882.10 85% = \$1,110.90		
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% = \$1,311.10		
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% = \$498.80		
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% = \$761.90		
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% = \$1,110.90		
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% = \$1,311.10		
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% = \$498.80		
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% = \$761.90		
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% = \$1,110.90		
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% = \$1,311.10		
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% = \$498.80		
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% = \$761.90		
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% = \$1,110.90		
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% = \$1,311.10		
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% = \$383.65
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% = \$500.10
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% = \$644.50
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% = \$769.70
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% = \$427.20
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% = \$378.15
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% = \$396.20
61364	BOWEL HAEMORRHAGE STUDY (R) Fee: \$496.95	Benefit: 75% = \$372.75	85% = \$431.75
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% = \$1,950.55
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% = \$424.50
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% = \$509.15
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% = \$559.75
61384	RADIONUCLIDE COLONIC TRANSIT STUDY (R) Fee: \$687.70	Benefit: 75% = \$515.80	85% = \$622.50
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% = \$366.15
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% = \$540.30
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% = \$539.85
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% = \$808.30

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% = \$414.60		
61425	BONE STUDY - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Fee: \$600.70 Benefit: 75% = \$450.55 85% = \$535.50		
61426	WHOLE BODY STUDY using iodine (R) Fee: \$554.80 Benefit: 75% = \$416.10 85% = \$489.60		
61429	WHOLE BODY STUDY using gallium (R) Fee: \$543.00 Benefit: 75% = \$407.25 85% = \$477.80		
61430	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) Fee: \$659.45 Benefit: 75% = \$494.60 85% = \$594.25		
61433	WHOLE BODY STUDY using cells labelled with technetium (R) Fee: \$496.95 Benefit: 75% = \$372.75 85% = \$431.75		
61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) Fee: \$615.40 Benefit: 75% = \$461.55 85% = \$550.20		
61437	WHOLE BODY STUDY using thallium (R) Fee: \$542.75 Benefit: 75% = \$407.10 85% = \$477.55		
61438	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) Fee: \$672.95 Benefit: 75% = \$504.75 85% = \$607.75		
61441	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) Fee: \$489.70 Benefit: 75% = \$367.30 85% = \$424.50		
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% = \$687.15		
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% = \$391.00		
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% = \$449.50		
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% = \$405.25		
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% = \$462.65		
+ 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) Fee: \$129.00 Benefit: 75% = \$96.75 85% = \$109.65		
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% = \$815.65		
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% = \$934.00		
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		
† 61505	CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 - 61650 (R) Fee: \$100.00 Benefit: 75% = \$75.00 85% = \$85.00		
61523	Whole body FDG PET study, performed for evaluation of a solitary pulmonary nodule where the lesion is considered unsuitable for transthoracic fine needle aspiration biopsy, or for which an attempt at pathological characterisation has failed.(R) Fee: \$953.00 Benefit: 75% = \$714.75 85% = \$887.80		
61529	Whole body FDG PET study, performed for the staging of proven non-small cell lung cancer, where curative surgery or radiotherapy is planned (R) Fee: \$953.00 Benefit: 75% = \$714.75 85% = \$887.80		
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (R) Fee: \$918.00 Benefit: 75% = \$688.50 85% = \$852.80		
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% = \$813.50		

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% = \$427.60	
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% = \$427.60	
63114	- inflammation of the central nervous system or meninges (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$427.60	
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% = \$427.60	
63128	- congenital malformation of the central nervous system or meninges (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$427.60	
63131	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$427.60	
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% = \$382.80	
63204	- tumour (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$382.80	
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% = \$382.80	
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% = \$382.80	
63225	- myelopathy (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$382.80	
63228	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$382.80	
63231	- cervical radiculopathy (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$382.80	
63234	- sciatica (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$382.80	
63237	- spinal canal stenosis (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$382.80	
63240	- previous spinal surgery (R) (Contrast) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$382.80	

MAGNETIC RESONANCE IMAGING		MRI
63243	- trauma (R) (Anaes.) Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$382.80	
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% = \$427.60	
63274	- trauma (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$427.60	
63277	- cervical radiculopathy (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$427.60	
63280	- previous surgery (R) (Contrast) (Anaes.) Fee: \$492.80 Benefit: 75% = \$369.60 85% = \$427.60	
SUBGROUP 11 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS		
MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:		
- tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (R) (Contrast) (Anaes.)		
63301	Fee: \$380.80 Benefit: 75% = \$285.60 85% = \$323.70	
- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (R) (Contrast) (Anaes.)		
63304	Fee: \$380.80 Benefit: 75% = \$285.60 85% = \$323.70	
- osteonecrosis (R) (Contrast) (Anaes.)		
63307	Fee: \$380.80 Benefit: 75% = \$285.60 85% = \$323.70	
SUBGROUP 12 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included by Subgroup 12 on three occasions only in any 12 month period		
MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:		
- derangement of hip or its supporting structures (R) (Contrast) (Anaes.)		
63322	Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	
- derangement of shoulder or its supporting structures (R) (Contrast) (Anaes.)		
63325	Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	
- derangement of knee or its supporting structures (R) (Contrast) (Anaes.)		
63328	Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	
- derangement of ankle and/or foot or its supporting structures (R) (Contrast) (Anaes.)		
63331	Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	
- derangement of one or both temporomandibular joints or their supporting structures (R) (Contrast) (Anaes.)		
63334	Fee: \$336.00 Benefit: 75% = \$252.00 85% = \$285.60	
- derangement of wrist and/or hand or its supporting structures (R) (Contrast) (Anaes.)		
63337	Fee: \$448.00 Benefit: 75% = \$336.00 85% = \$382.80	
- derangement of elbow or its supporting structures (R) (Contrast) (Anaes.)		
63340	Fee: \$403.20 Benefit: 75% = \$302.40 85% = \$342.75	

MAGNETIC RESONANCE IMAGING		MRI
SUBGROUP 13 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included by Subgroup 13 on two occasions only in any 12 month period		
MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:		
63361	- Gaucher disease (R) (Anaes.) Fee: \$403.20	Benefit: 75% = \$302.40 85% = \$342.75
SUBGROUP 14 - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included by Subgroup 14 on two occasions only in any 12 month period		
MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cardiovascular system for:		
63385	- congenital disease of the heart or a great vessel (R) (Contrast) (Anaes.) Fee: \$448.00	Benefit: 75% = \$336.00 85% = \$382.80
63388	- tumour of the heart or a great vessel (R) (Contrast) (Anaes.) Fee: \$448.00	Benefit: 75% = \$336.00 85% = \$382.80
63391	- abnormality of thoracic aorta (R) (Contrast) (Anaes.) Fee: \$403.20	Benefit: 75% = \$302.40 85% = \$342.75
SUBGROUP 15 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included by Subgroup 15 on three occasions only in any 12 month period		
MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - scan of cardiovascular system for:		
63401	- vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.) Fee: \$403.20	Benefit: 75% = \$302.40 85% = \$342.75
63404	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) (Anaes.) Fee: \$403.20	Benefit: 75% = \$302.40 85% = \$342.75
SUBGROUP 16 - MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS		
NOTE: Benefits are payable for each service included by Subgroup 16 on one occasion only in any 12 month period		
MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:		
63416	- the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Contrast) (Anaes.) Fee: \$403.20	Benefit: 75% = \$302.40 85% = \$342.75
SUBGROUP 17 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS		
NOTE: Benefits are payable for each service included by Subgroup 17 on two occasions only in any 12 month period, for previously diagnosed conditions		
MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:		
63425	- post-inflammatory or post-traumatic physal fusion (R) (Anaes.) Fee: \$403.20	Benefit: 75% = \$302.40 85% = \$342.75

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% = \$562.00	
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

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.

Modifying items for use with MAGNETIC RESONANCE IMAGING or MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician. **Scan performed:**

- involves the use of contrast agent for eligible Magnetic Resonance Imaging items (Note: (Contrast) denotes an item eligible for use with this item)

63491 **Fee:** \$44.80 **Benefit:** 75% = \$33.60 85% = \$38.10

- involves use of intravenous or intramuscular sedation on a patient

63494 **Fee:** \$44.80 **Benefit:** 75% = \$33.60 85% = \$38.10

- on a patient under anaesthetic in the presence of a medical practitioner qualified to perform an anaesthetic

63497 **Fee:** \$156.80 **Benefit:** 75% = \$117.60 85% = \$133.30

A	
Abdomen, barium X-ray	58909
Abdominal X-ray, plain	58900, 58903
Air contrast study with opaque enema	58921
Air insufflation	59763
Alimentary tract, X-ray of	58900 - 58921
Angiocardiology	59903
Angiography	
- cerebral, preparation for	60918
- coronary	59912
- digital subtraction (DSA)	60000 - 60069
- with mobile image intensification	59970
Ankle, X-ray of	57518 - 57527
Antegrade pyelography	58715
Arm, X-ray of	57506 - 57515
Arteriogram - selective, preparation	60927
Arteriography	59912
- preparation for	60918
- selective	59912
- preparation for	38215, 38218
Arteriography or Venography	60072 - 60078
- selective	
Arthrography	59751

B	
Barium, alimentary tract	58909, 58912, 58915
Biliary system, X-ray of	58924 - 58936
Bone age study	58300
Bowel - small, barium X-ray of	58912, 58915
Bowel - small, enema	58916
Breast X-ray - restriction applies	59300, 59303
Breast X-ray, with surgical procedure	59312, 59314
Breast X-ray, excised tissue	59318
Bronchography	59715
Bulk-billing	64990, 64991

C	
Calculus, salivary, X-ray of	57918
Cerebral angiography	
- preparation for	60918
Cephalometry, X-ray	57902
Cervical spine, X-ray of	58100
Chest, X-ray of	58500 - 58509
Cholecystography	58924
Cholegraphy	58927, 58933, 58936
Clavicle, X-ray of	57706, 57709

Coccyx, X-ray of	58109
Colon, X-ray of	58912, 58921
Computerised Tomography	
- Brain, chest and upper abdomen	57001, 57007, 57041, 57047
- Chest, abdomen, pelvis, neck	56801, 56807, 56841, 56847
- Chest and upper abdomen	56301, 56307, 56341, 56347
- Extremities	56619, 56625, 56659, 56665
- Head	
- brain	56001, 56007, 56041, 56047
- pituitary fossa	56010, 56050
- orbits	56013, 56053
- middle ear	56016, 56056
- facial bones	56022, 56028, 56062, 56068
- Interventional technique	57341, 57345
- Neck	56101, 56107, 56141, 56147
- Pelvis	56409, 56412, 56449, 56452
- Pelvimetry	57201, 57247
- Spine	56219 - 56259
- Spiral angiography	57350, 57355, 57351, 57356
- Upper abdomen	56401, 56407, 56441, 56447
- Upper abdomen & pelvis	56501, 56507, 56541, 56547, 56549, 56551
Colon	
Contrast media, intro for radiology	60918
Coronary arteriography, selective	59912
Cystography, retrograde	58718
Cysto-urethrography, retrograde micturating	58721

D	
Dacryocystography	59703
Defaecogram,	58939
Digital subtraction angiography (see angiography)	
Digits & Phalanges	57506 - 57527
Discography	59700
Duodenum, barium X-ray of	58909, 58912
Duplex scanning, of	
- abdominal aorta	55276
- arteries, iliac arteries and veins	
- arteries/grafts lower limb	55238
- arteries/grafts upper limb	55248

- carotid and vertebral vessels	55274
- intra-cranial vessels	55280
- penis, cavernosal artery	55282
- penis, cavernosal tissue	55284
- renal/visceral vessels	55278
- veins lower limb, venous disease	55246
- veins lower limb, venous thrombosis	55244
- veins upper limb	55252

E

Echocardiographic exam of heart	55113 - 55135
Echography, ultrasonic	55028 - 55854
Elbow, X-ray	57506, 57509
Enema, opaque X-ray	58921
Eye, X-ray of	57924

F

Facial bones, X-ray of	57912
Femur, X-ray of	57518, 57527, 57721, 57724
Fistulogram	59739
Fluoroscopic exam	60500 - 60509, 61109
screening palate/pharynx, X-ray	57939
screening with X-ray of chest	58506
Foot, X-ray of	57518 - 57527
Forearm, X-ray of	57506, 57515
Foreign body, localisation of and report	59103

G

Gallbladder, X-ray of	58924 - 58936
Graham's test	58924

H

Hand/wrist/forearm/elbow/	57506 - 57515
Hip joint, X-ray of	57712
Humerus, X-ray of	57506 - 57509, 57512, 57515
Hysterosalpingography	59712

I

Intravenous pyelography	58706
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K

Knee/foot/ankle/leg/femur X-ray	57518 - 57527
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L

Larynx, neck tissues, X-ray of	57945
Leg, X-ray of	57518 - 57527
Lumbo-sacral spine, X-ray of	58106
Lung fields, X-ray of	58500, 58503, 58506
Lymphangiography	59754

M

Magnetic Resonance

Angiography

- Cardiovascular system	63401 - 63404
- person under 16 years	63416

Magnetic Resonance

Imaging

- Head	63001 - 63073
- Head and Neck vessels	63101
- Head and cervical spine	63125 - 63131
- Spine – one region or two contiguous regions	63151 - 63185
- Spine – three contiguous or two non contiguous regions	63201 - 63243
- Cervical spine and brachial plexus	63271 - 63280
- Musculoskeletal system	63301 - 63361
- Cardiovascular system	63385 - 63391
- Person under 16 years	63425 - 63446
- Body	63461
- Pelvis and upper abdomen	63470 – 63473
- Modifying items	63491 - 63497
Malar bones, X-ray of	57912
Mammary ductogram	59306, 59309
Mammography (restriction applies)	59300, 59303
Mandible, X-ray of	57915
Mastoids, X-ray of	57906
Maxilla, X-ray of	57912
Myelography	59724

N

Nephrography	58700 - 58715
Nose, X-ray of	57921

Nuclear medicine imaging

cardiovascular

- cardiac blood flow, shunt/output study	61320
- gated cardiac study- planar or spect	61313
- gated cardiac study- 1st pass/cardiac	61314
- gated cardiac study- intervention	61316
- gated cardiac study- flow/shunt study	61317

- myocardial infarct-avid imaging 61310
- myocardial perfusion 61302 - 61307
- central nervous
 - brain study 61402, 61405
 - cerebro spinal fluid study 61409, 61413
- endocrine
 - adrenal study 61484, 614 85
 - parathyroid study 61480
 - thyroid study 61473
- gastrointestinal
 - bowel haemorrhage study 61364
 - colonic transit study 61384
 - gastric emptying 61381, 61383
 - gastro-oesophageal reflux study 61373
 - oesophageal clearance study 61376
 - hepatobiliary study 61360, 61361
- Indium
 - labelled octreotide study 61369
 - Meckel's diverticulum study 61368
 - red blood cell spleen/liver SPECT 61356
 - salivary study 61372
- genitourinary
 - cystoureterogram 61397
 - renal cortical study 61387
 - renal study 61386, 61389, 61390, 61393
 - renal study including renogram or planar 61386
 - testicular study 61401
- liver and spleen study 61352, 61353
- localised study
 - gallium 61450, 61453
 - technetium 61454, 61457
 - thallium 61458, 61461
- lymphoscintigraphy 61469
- pulmonary
 - lung perfusion study 61328
 - lung perfusion & ventilation 61348
 - lung ventilation study 61340
- repeat planar or SPECT 61462
- skeletal
 - bone marrow study 61441, 61445
 - bone study 61421, 61425
 - bone/joint localised 61446, 61449
- tear duct study 61495
- vascular
 - dynamic flow/volume study 61417
 - particle perfusion or Le Veen 61499
 - venography 61465

- whole body study
 - gallium 61429, 61430, 61442
 - iodine 61426
 - technetium 61433, 61434
 - thallium 61437, 61438

O

- Oesophagus, barium X-ray of 58909, 58912
- Opaque enema 58921
 - meal 58909, 58912, 58915
 - media, radiology prep 60918 - 60927
- Orbit, facial bones, X-ray of 57912
- Orthopantomography 57960, 57963, 57966, 57969

P

- Palato-pharyngeal studies 57939, 57942
- Pelvic girdle, X-ray of 57715
- Pelvimetry 59503
- Pelvis, X-ray of 57715
- Peritoneogram 59760
- Petrous temporal bones, X-ray of 57909
- Phalanges & digits 57506 - 57527
- Pharynx, barium X-ray of 58909
- Phlebogram, preparation 60927
- Phlebography 59718
 - preparation for 60918
- Plain abdominal X-ray 58900, 58903
- Plain renal X-ray 58700
- Pleura, X-ray of 58500, 58503
- Prep for radiological procedure 60918 - 60927
- Pyelography - intravenous 58706
 - retrograde/antegrade 58715

R

- Radioisotope studies (see nuclear)
- Renal, plain X-ray 58700
- Retrograde - pyelography 58715
 - cystography 58718
 - cysto-urethography 58721
- Ribs, X-ray of 58521, 58524, 58527

S

- Sacro-coccygeal spine, X-ray of 58109
- Salivary calculus, X-ray of 57918
- Scapula, X-ray of 57700, 57703
- Serial angiocardiology 59903
- Shoulder or scapula, X-ray 57700, 57703

of	
Sialography	59733
Sinogram or fistulogram	59739
Sinus, X-ray of	57903
Skeletal survey	58306
Skull, X-ray	57901
Small bowel series, barium, X-ray	58912, 58915
Spine, X-ray of	58100 - 58115
Sternum, X-ray of	58521, 58524, 58527
Stomach, barium X-ray	58909, 58912

T

Teeth	
- orthopantomography	57960, 57963, 57966, 57969
- X-ray of	57930, 57933
Temporo-mandibular joints, X-ray of	57927
Thigh, (femur), X-ray of	57518, 57521
Thoracic inlet, X-ray of	58509
- spine, X-ray of	58103
Tomography, any region	60100
Trachea, X-ray of	58509

U

Ultrasound	
- general	55028 - 55085
- cardiac examination	55113 - 55135
- vascular	55238 - 55296
- urological	55600, 55603
- obstetric and gynaecological	55700 - 55774
- musculoskeletal	55800, 55854
Upper forearm & elbow, X-ray	57512, 57515
- leg and knee, X-ray of	57524, 57527
Urethrography, retrograde	58718
Urinary tract, X-ray of	58700 - 58721

V

Vasoepididymography	59736
Venography, selective	60072 - 60078

W

Wrist/hand/forearm/elbow/humerus X-ray of	57506 - 57515
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X

X-ray	
- extremities	57506 - 57527
- shoulder or pelvis	57700 - 57721
- Head	57901 - 57969
- Spine	58100 - 58115
- Bone age study and	58300 - 58306

skeletal surveys	
- Thoracic region	58500 - 58527
- Urinary tract	58700 - 58721
- Alimentary tract and biliary system	58900 - 58939
- Breasts	59300, 59303
- Breasts - mammary ductogram	59306, 59309
- Breasts - in conjunction with a surgical procedure	59312, 59314
- Of excised breast issue	59318
- In connection with pregnancy	59503
- With opaque or contrast media	59700 - 59763
X-ray image intensification	60500, 60503

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;
- tissue banking and preparation procedures;
- pathology services performed on stillborn babies or cadavers;
- 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.

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; or in the case of a referred test, the name of the original requesting practitioner;
- (v) the date on which the request was made; or in the case of a referred test, the date on which the original 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 privately referred out-patient of a recognised hospital.

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 benefits are two-tiered. Higher benefits are paid for the collection of specimens from patients who are not private inpatients or private outpatients of a recognised hospital where the specimens are tested in a private laboratory.

A lower and uniform PEI benefit is paid where patients are private patients associated with a recognised hospital and the specimens are tested in a private laboratory or where the testing is performed by a prescribed laboratory on specimen collected from a patient eligible to claim Medicare benefits.

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.secretariat@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 65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66609, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69419, 69451, 69500, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318 and 73321); 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 discussion should be provided to the patient. Further discussion 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 unREFERRED pathology services performed by a medical practitioner which are included in Group P9 of the Pathology Services Table, and unREFERRED pathology services provided by category M laboratories;
- Item 74990 and item 74991 applies to pathology services self determined by general practitioners and specialists with dual qualifications acting in their capacity as general practitioners;
- Specialists and consultant physicians who provide pathology services are not able to claim item 74990 or item 74991 unless, for the purposes of the Health Insurance Act, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to that practitioner by another medical practitioner or person with referring rights.

Rules 3 and 18 of the *Health Insurance (Pathology Services Table) Regulations 2003* have been amended to exclude item 74990 and 74991 from the Multiple Services Rule and the Coning Rule.

Item 74991 can only be used where the service is provided at, or from, a practice location in a regional, rural or remote area (RRMA 3 to 7 under the Rural Remote Metropolitan Areas classification system), or in all of Tasmania.

PP.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 isoemzymes, 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), Lactate dehydrogenase (LDH), and Protein (PROT)	LFT	66515
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.

receiving APP means an approved pathology practitioner in an approved pathology authority who performs one or more pathology services in respect of a single patient episode following receipt of a request for those services from a referring APP.

recognised pathologist means a medical practitioner recognised as a specialist in pathology by a determination under section 3D, 3DB or 3E of the Act.

referring APP means an approved pathology practitioner in an approved pathology authority who:

- (i) has been requested to render 1 or more pathology services, all of which are requested in a single patient episode; 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 of the pathology services; and
- (iii) requests an approved pathology practitioner (the **receiving APP**) in another approved pathology authority to render the pathology service or services that the referring APP is unable to render; and
- (iv) renders each pathology service (if any) included in that patient episode, other than the pathology service or services in respect of which the request mentioned in subparagraph (iii) is made.

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".
4. (3) Rule 3 does not apply to a pathology service described in items 65109 or 65110 if:
- (a) The service is rendered on not more than 5 separate occasions in the case of item 65109 and 2 separate occasions in the case of item 65110 in a period of 24 hours; and
 - (b) The service is rendered in response to a written request separated in time from the previous request; and
 - (c) 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 tests of the kind described in item 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165.

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 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 (if any) 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 65156, 65179, 66653, 66710, 66712, 66734, 66788, 66806, 66815, 66822, 66828, 69399, 69496, 71093, 71159 or 71168.

6. (3) If this rule applies in respect of a designated pathology service:

(a) item 65150, 65153, 65175, 65176, 65177, 65178, 66650, 66695, 66698, 66701, 66704, 66707, 66711, 66722, 66725, 66728, 66731, 66785, 66800, 66803, 66812, 66819, 66825, 69384, 69387, 69390, 69393, 69396, 69494, 69495, 71089, 71091, 71153, 71155, 71157, 71165, 71166 or 71167 (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) and:

- (i) practitioner A has rendered one or more of the tests that the service comprises - subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each test that the service comprises; or
- (ii) practitioner A has not rendered any of the tests that the service comprises -
 - (A) the amount specified in item 65157, 65180, 66651, 66696, 66714, 66723, 66789, 66804, 66816, 66820, 66826, 69400, 69497, 71090, 71154 or 71169 (as the case requires) shall be taken to be the fee for the first test that the service comprises; and
 - (B) subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each subsequent test that the service comprises.

6. (4) For paragraph (3) (b), the maximum number of tests to which item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 applies is:

- (a) for item 66652, 66715, 66790, 66817, 66821 or 66827:
2 - X; and
- (b) for item 65158, 66805, 69498 or 71092:
3 - X; and
- (c) for item 71156 or 71170:
4 - X; and
- (d) for item 65181 or 66724:

- 5 – X; and
(e) for item 66697 or 69401:
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).
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, 72836 and 72838 are performed in a single patient episode, only the fee for the item performed having the highest specified fee is applicable to the services.
- 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, 72836 and 72838 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 a service provided to a public patient in a recognised hospital or when attending an outpatient service of a recognised hospital.
- 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;the fee specified in the applicable item in Group P10 applies once only to the services unless an exemption listed in Rule 4 applies or an exemption has been granted under Rule 3 “S4B(3)”.
- 14. (9)** The amount specified in item 73940 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 73940 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 73940 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) excludes services referred to in an item in Group P10, Group P11 or Group P12, items 73053 and 73055; and
 - (e) excludes services described in the following items:
- 65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66609, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69419, 69451, 69500, 69484, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318 and 73321;
- where those services are performed by an approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority following referral by another approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority which is not **related to** the first mentioned approved pathology authority.
- (1A) An approved pathology authority is **related to** another approved pathology authority for the purposes of paragraph 18(1)(e) if that approved pathology authority would be related to the other approved pathology authority for the purposes of rule 16(2).
- 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 1 pathology service under paragraph (3) (c) or (4) (c), the fee for the 1 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 69499 and 69500:
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 items 73317 and 73318:
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 66819, 66820, 66821 and 66822.
metal toxicity testing group means items 66825, 66826, 66827 and 66828.
- 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, 66605, 69418, 69419, 69488, 69489, 71075, 71127, 71135 or 71137 is 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, 69482, 69491 or 69492, 69499 or 69500 are applicable not more than once in a 12 month period.
 - (d) For any particular patient, item 66750 or 66751 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 66551, 69445, 69451, 69483, 71079, or 73314, 73315, 73523 are applicable not more than 4 times in a 12 month period.
 - (g) For any particular patient, items 66554, 66830 and 71077 are applicable not more than 6 times in a 12 month period.
 - (h) For any particular patient, item 66819, 66820, 66821, 66822, 66825, 66826, 66827 or 66828 is applicable not more than 3 times in a 6 month period.

Antigen Detection – Group P3 (Microbiology)

26. If the service listed in 69316, 69317, 69319, 69494, 69495, 69496, 69497 or 69498 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 71148, 73320 or 73321 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	
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
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: \$110.80	Benefit: 75% = \$83.10 85% = \$94.20
+ 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: \$167.50	Benefit: 75% = \$125.65 85% = \$142.40
+ 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: \$110.80	Benefit: 75% = \$83.10 85% = \$94.20
+ 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: \$167.50	Benefit: 75% = \$125.65 85% = \$142.40
† 65109	Release of fresh frozen plasma or cryoprecipitate for the use in a patient for the correction of a coagulopathy – 1 release.	Fee: \$13.10	Benefit: 75% = \$9.85 85% = \$11.15
† 65110	Release of compatible fresh platelets for the use in a patient for platelet support as prophylaxis to minimize bleeding or during active bleeding – 1 release.	Fee: \$13.10	Benefit: 75% = \$9.85 85% = \$11.15
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

PATHOLOGY		PATHOLOGY	
† 65166	A test described in item 65165 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	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
‡ * 65175	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 (Item is subject to Rule 6)	Fee: \$25.75	Benefit: 75% = \$19.35 85% = \$21.90
+ * 65176	2 tests described in item 65175 (Item is subject to rule 6)	Fee: \$49.45	Benefit: 75% = \$37.10 85% = \$42.05
* 65177	3 tests described in item 65175 (Item is subject to rule 6)	Fee: \$73.20	Benefit: 75% = \$54.90 85% = \$62.25
‡ + * 65178	4 tests described in item 65175 (Item is subject to rule 6)	Fee: \$96.85	Benefit: 75% = \$72.65 85% = \$82.35
+ * 65179	5 tests described in item 65175 (Item is subject to rule 6)	Fee: \$120.55	Benefit: 75% = \$90.45 85% = \$102.50
† 65180	A test described in item 65175, if rendered by a receiving APA, where no tests in the item have been rendered by the referring APA - 1 test (Item is subject to rule 6 and 18)	Fee: \$25.75	Benefit: 75% = \$19.35 85% = \$21.90
† 65181	Tests described in item 65175, other than that described in 65180, if rendered by a receiving APA - each test to a maximum of 4 tests (Item is subject to rule 6 and 18)	Fee: \$23.70	Benefit: 75% = \$17.80 85% = \$20.15

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
† 66606	A test described in item 66605 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18 and 25) Fee: \$31.15	Benefit: 75% = \$23.40	85% = \$26.50

PATHOLOGY		PATHOLOGY	
66608	Vitamin D or D fractions - 1 or more tests Fee: \$43.00	Benefit: 75% = \$32.25	85% = \$36.55
† 66609	A test described in item 66608 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) Fee: \$43.00	Benefit: 75% = \$32.25	85% = \$36.55
66623	All qualitative and quantitative tests on blood, urine or other body fluid for: (a) a drug or drugs of abuse (including illegal drugs and legally available drugs taken other than in appropriate dosage); or (b) ingested or absorbed toxic chemicals; including a service described in item 66800, 66803, 66806, 66812 or 66815 (if performed), but excluding: (c) the surveillance of sports people and athletes for performance improving substances; and (d) the monitoring of patients participating in a drug abuse treatment program Fee: \$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 (Item is subject to rule 18) 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
† 66639	A test described in item 66638 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) 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
† 66642	A test described in item 66641 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) 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 (Item is subject to rule 6) Fee: \$24.75	Benefit: 75% = \$18.60	85% = \$21.05
† 66651	A test described in item 66650 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) Fee: \$24.75	Benefit: 75% = \$18.60	85% = \$21.05

PATHOLOGY		PATHOLOGY	
† 66652	A test described in item 66650 if rendered by a receiving APP - other than that described in 66651, if rendered by a receiving APP, 1 test (Item is subject to rule 6 and 18)	Fee: \$20.65	Benefit: 75% = \$15.50 85% = \$17.60
‡ + 66653	2 or more tests described in item 66650 (Item is subject to rule 6)	Fee: \$45.40	Benefit: 75% = \$34.05 85% = \$38.60
‡ 66655	Prostate specific antigen - quantitation - 1 of this item in a 12 month period (Item is subject to rule 25)	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 (Item is subject to rule 25)	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
† 66663	A test described in item 66662 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	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
† 66666	A test described in item 66665 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	Fee: \$31.15	Benefit: 75% = \$23.40 85% = \$26.50
66667	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test	Fee: \$31.15	Benefit: 75% = \$23.40 85% = \$26.50
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
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

PATHOLOGY		PATHOLOGY	
‡ 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 (Item is subject to rule 6)	Fee: \$30.70	Benefit: 75% = \$23.05 85% = \$26.10
† 66696	A test described in item 66695, if rendered by a receiving APP - where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18)	Fee: \$30.70	Benefit: 75% = \$23.05 85% = \$26.10
† 66697	Tests described in item 66695, other than that described in 66696, if rendered by a receiving APP - each test to a maximum of 5 tests (Item is subject to rule 6 and 18)	Fee: \$13.30	Benefit: 75% = \$10.00 85% = \$11.35
+ 66698	2 tests described in item 66695 (Item is subject to rule 6)	Fee: \$44.00	Benefit: 75% = \$33.00 85% = \$37.40
+ 66701	3 tests described in item 66695 (Item is subject to rule 6)	Fee: \$57.30	Benefit: 75% = \$43.00 85% = \$48.75
66704	4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	Fee: \$70.60	Benefit: 75% = \$52.95 85% = \$60.05
+ 66707	5 tests described in item 66695 (Item is subject to rule 6)	Fee: \$83.90	Benefit: 75% = \$62.95 85% = \$71.35
66710	6 or more tests described in item 66695 (Item is subject to rule 6)	Fee: \$97.45	Benefit: 75% = \$73.10 85% = \$82.85
‡ 66711	Quantitation in saliva of cortisol in: (a) the investigation of Cushing's syndrome; or (b) the management of children with congenital adrenal hyperplasia (Item is subject to rule 6)	Fee: \$30.70	Benefit: 75% = \$23.05 85% = \$26.10
‡ 66712	Two tests described in item 66711 (Item is subject to rule 6)	Fee: \$43.80	Benefit: 75% = \$32.85 85% = \$37.25
† 66714	A test described in item 66711, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18)	Fee: \$30.70	Benefit: 75% = \$23.05 85% = \$26.10
† 66715	Tests described in item 66711, other than that described in 66714, if rendered by a receiving APP, each test to a maximum of 1 test (Item is subject to rule 6 and 18)	Fee: \$13.10	Benefit: 75% = \$9.85 85% = \$11.15
66716	TSH quantitation	Fee: \$25.45	Benefit: 75% = \$19.10 85% = \$21.65

PATHOLOGY		PATHOLOGY	
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> <ul style="list-style-type: none"> (a) the patient has an abnormal level of TSH; (b) the tests are performed: <ul style="list-style-type: none"> (i) for the purpose of monitoring thyroid disease in the patient; or (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or (iii) to investigate dementia or psychiatric illness of the patient; or (iv) to investigate amenorrhoea or infertility of the patient; (c) the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction; (d) the patient is on drugs that interfere with thyroid hormone metabolism or function <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
† 66723	<p>Tests described in item 66722, that is, TSH quantitation and 1 test described in 66695, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test</p> <p>(Item is subject to rule 6 and 18)</p>	Fee: \$38.55	Benefit: 75% = \$28.95 85% = \$32.80
† 66724	<p>Tests described in item 66722, if rendered by a receiving APP, other than that described in 66723. It is to include a quantitation of TSH - each test to a maximum of 4 tests described in item 66695</p> <p>(Item is subject to rule 6 and 18)</p>	Fee: \$13.40	Benefit: 75% = \$10.05 85% = \$11.40
66725	<p>TSH quantitation described in item 66716 and 2 tests described in item 66695</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 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: \$51.95	Benefit: 75% = \$39.00 85% = \$44.20
66728	<p>TSH quantitation described in item 66716 and 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 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: \$65.35	Benefit: 75% = \$49.05 85% = \$55.55
66731	<p>TSH quantitation described in item 66716 and 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 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: \$78.75	Benefit: 75% = \$59.10 85% = \$66.95
66734	<p>TSH quantitation described in item 66716 and 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 6 or more tests specified on the request form)</p> <p>(Item is subject to rule 6)</p>	Fee: \$92.15	Benefit: 75% = \$69.15 85% = \$78.35
66743	<p>Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751</p>	Fee: \$20.50	Benefit: 75% = \$15.40 85% = \$17.45

PATHOLOGY		PATHOLOGY	
66749	Amniotic fluid, spectrophotometric examination of, and quantitation of: (a) lecithin/sphingomyelin ratio; or (b) palmitic acid, phosphatidylglycerol or lamellar body phospholipid; or (c) bilirubin, including correction for haemoglobin 1 or more tests Fee: \$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) - (Item is subject to rule 25) Fee: \$40.45	Benefit: 75% = \$30.35	85% = \$34.40
‡ 66751	Quantitation, in pregnancy, of any three or more tests described in 66750 (Item is subject to rule 25) Fee: \$56.20	Benefit: 75% = \$42.15	85% = \$47.80
‡ 66752	Quantitation of citrate, oxalate, total free fatty acids, cysteine, homocysteine, cystine or other amino acids 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
† 66756	Quantitation of 10 or more amino acids for the diagnosis of inborn errors of metabolism - up to 4 tests in a 12 month period on specimens of plasma, CSF and urine. Fee: \$100.00	Benefit: 75% = \$75.00	85% = \$85.00
† 66757	Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type. Fee: \$100.00	Benefit: 75% = \$75.00	85% = \$85.00
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
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 or formation 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 or formation 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

PATHOLOGY		PATHOLOGY	
† 66780	A test described in item 66779 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	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
† 66783	A test described in item 66782 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	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 (Item is subject to rule 6)	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 (Item is subject to rule 6)	Fee: \$67.00	Benefit: 75% = \$50.25 85% = \$56.95
† 66789	A test described in item 66785 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18)	Fee: \$40.65	Benefit: 75% = \$30.50 85% = \$34.60
† 66790	A test described in item 66785 other than that described in 66786, if rendered by a receiving APP - to a maximum of 1 test (Item is subject to rule 6 and 18)	Fee: \$26.35	Benefit: 75% = \$19.80 85% = \$22.40
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
† 66792	A test described in item 66791 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	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) <i>(See para PP.6 of explanatory notes to this Category)</i>	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
† 66804	A test described in item 66800 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18)	Fee: \$18.45	Benefit: 75% = \$13.85 85% = \$15.70
† 66805	A test described in item 66800 other than that described in 66804, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18)	Fee: \$12.60	Benefit: 75% = \$9.45 85% = \$10.75
+ 66806	3 tests described in item 66800 (Item is subject to rule 6)	Fee: \$43.65	Benefit: 75% = \$32.75 85% = \$37.15

PATHOLOGY		PATHOLOGY	
66812	Quantitation, not elsewhere described in this Table by any method or methods, in blood, urine or other body fluid, of a drug being used therapeutically by the patient from whom the specimen was taken - 1 test (This fee applies where 1 laboratory performs the only test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) (See para PP.6 of explanatory notes to this Category)	Fee: \$35.45	Benefit: 75% = \$26.60 85% = \$30.15
66815	2 tests described in item 66812 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	Fee: \$60.60	Benefit: 75% = \$45.45 85% = \$51.55
† 66816	A test described in item 66812 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18)	Fee: \$35.45	Benefit: 75% = \$26.60 85% = \$30.15
† 66817	A test described in item 66812, other than that described in 66816, if rendered by a receiving APP - to a maximum of 1 test (Item is subject to rule 6 and 18)	Fee: \$25.15	Benefit: 75% = \$18.90 85% = \$21.40
* 66819	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 6, 22 and 25)	Fee: \$31.15	Benefit: 75% = \$23.40 85% = \$26.50
† 66820	A test described in item 66819 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6, 18, 22 and 25)	Fee: \$31.15	Benefit: 75% = \$23.40 85% = \$26.50
† 66821	A test described in item 66819 other than that described in 66820 if rendered by a receiving APP to a maximum of 1 test (Item is subject to rule 6, 18, 22 and 25)	Fee: \$22.20	Benefit: 75% = \$16.65 85% = \$18.90
* 66822	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 6, 22 and 25)	Fee: \$53.35	Benefit: 75% = \$40.05 85% = \$45.35
* 66825	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 6, 22 and 25)	Fee: \$31.15	Benefit: 75% = \$23.40 85% = \$26.50
† 66826	A test described in item 66825 if rendered by a receiving APP where no tests have been rendered by the referring APP - 1 test (Item is subject to rules 6, 18, 22 and 25)	Fee: \$31.15	Benefit: 75% = \$23.40 85% = \$26.50
† 66827	A test described in item 66825, other than that described in 66826, if rendered by a receiving APP to a maximum of 1 test (Item is subject to rules 6, 18, 22 and 25)	Fee: \$22.20	Benefit: 75% = \$16.65 85% = \$18.90
* 66828	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 6, 22 and 25)	Fee: \$53.35	Benefit: 75% = \$40.05 85% = \$45.35

PATHOLOGY		PATHOLOGY	
GROUP P3 - MICROBIOLOGY			
69300	Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including: (a) differential cell count (if performed); or (b) examination for dermatophytes; or (c) dark ground illumination; or (d) stained preparation or preparations using any relevant stain or stains; 1 or more tests	Fee: \$12.60	Benefit: 75% = \$9.45 85% = \$10.75
69303	Culture and (if performed) microscopy to detect pathogenic micro-organisms from nasal swabs, throat swabs, eye swabs and ear swabs (excluding swabs taken for epidemiological surveillance), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300; specimens from 1 or more sites	Fee: \$22.15	Benefit: 75% = \$16.65 85% = \$18.85
69306	Microscopy and culture to detect pathogenic micro-organisms from skin or other superficial sites, including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69312, 69318; 1 or more tests on 1 or more specimens	Fee: \$34.00	Benefit: 75% = \$25.50 85% = \$28.90
69309	Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens	Fee: \$48.45	Benefit: 75% = \$36.35 85% = \$41.20
69312	Microscopy and culture to detect pathogenic micro-organisms from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69306 and 69318; 1 or more tests on 1 or more specimens	Fee: \$34.00	Benefit: 75% = \$25.50 85% = \$28.90
† 69316	Detection of Chlamydia trachomatis by any method - 1 test (Item is subject to rule 26)	Fee: \$28.85	Benefit: 75% = \$21.65 85% = \$24.55
† 69317	1 test described in item 69494 and a test described in 69316. (Item is subject to rule 26)	Fee: \$36.10	Benefit: 75% = \$27.10 85% = \$30.70
69318	Microscopy and culture to detect pathogenic micro-organisms from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69306 and 69312; 1 or more tests on 1 or more specimens	Fee: \$34.00	Benefit: 75% = \$25.50 85% = \$28.90
† 69319	2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26)	Fee: \$43.25	Benefit: 75% = \$32.45 85% = \$36.80
69321	Microscopy and culture of post-operative wounds, aspirates of body cavities, synovial fluid, CSF or operative or biopsy specimens, for the presence of pathogenic micro-organisms involving aerobic and anaerobic cultures and the use of different culture media, and including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300, 69303, 69306, 69312 or 69318; specimens from 1 or more sites	Fee: \$48.45	Benefit: 75% = \$36.35 85% = \$41.20
69324	Microscopy (with appropriate stains) and culture for mycobacteria - 1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300	Fee: \$43.30	Benefit: 75% = \$32.50 85% = \$36.85

PATHOLOGY		PATHOLOGY	
† 69325	A test described in item 69324 if rendered by a receiving APP (Item is subject to rule 18)	Fee: \$43.30	Benefit: 75% = \$32.50 85% = \$36.85
69327	Microscopy (with appropriate stains) and culture for mycobacteria - 2 specimens of sputum, urine, or other body fluid or 2 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300	Fee: \$85.55	Benefit: 75% = \$64.20 85% = \$72.75
† 69328	A test described in item 69327 if rendered by a receiving APP (Item is subject to rule 18)	Fee: \$85.55	Benefit: 75% = \$64.20 85% = \$72.75
69330	Microscopy (with appropriate stains) and culture for mycobacteria - 3 specimens of sputum, urine, or other body fluid or 3 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300	Fee: \$128.85	Benefit: 75% = \$96.65 85% = \$109.55
† 69331	A test described in item 69330 if rendered by a receiving APP (Item is subject to rule 18)	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

PATHOLOGY		PATHOLOGY	
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		
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		
† 69379	A test described in item 69378 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) 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		
† 69383	A test described in item 69381 if rendered by a receiving APP - 1 or more tests on 1 or more specimens (Item is subject to rule 18) Fee: \$181.45 Benefit: 75% = \$136.10 85% = \$154.25		
‡ 69384	Quantitation of 1 antibody to microbial antigens not elsewhere described in the Schedule - 1 test (This fee applies where a laboratory performs the only antibody test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) (See para PP.7 and PP.13 of explanatory notes to this Category) 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) (See para PP.7 and PP.13 of explanatory notes to this Category) Fee: \$29.75 Benefit: 75% = \$22.35 85% = \$25.30		
+ 69390	3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) (See para PP.7 and PP.13 of explanatory notes to this Category) Fee: \$43.75 Benefit: 75% = \$32.85 85% = \$37.20		
69393	4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 estimations specified on the request form or performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) (See para PP.7 and PP.13 of explanatory notes to this Category) 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) (See para PP.7 and PP.13 of explanatory notes to this Category) Fee: \$71.75 Benefit: 75% = \$53.85 85% = \$61.00		

PATHOLOGY		PATHOLOGY	
‡ + 69399	6 or more tests described in item 69384 (Item is subject to rule 6) (See para PP.7 and PP.13 of explanatory notes to this Category)	Fee: \$85.75	Benefit: 75% = \$64.35 85% = \$72.90
† 69400	A test described in item 69384, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18)	Fee: \$15.75	Benefit: 75% = \$11.85 85% = \$13.40
† 69401	A test described in item 69384, other than that described in 69400, if rendered by a receiving APP - each test to a maximum of 5 tests (Item is subject to rule 6 and 18)	Fee: \$14.00	Benefit: 75% = \$10.50 85% = \$11.90
69405	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 1 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)	Fee: \$15.75	Benefit: 75% = \$11.85 85% = \$13.40
69408	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 2 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)	Fee: \$28.00	Benefit: 75% = \$21.00 85% = \$23.80
69411	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 3 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)	Fee: \$39.35	Benefit: 75% = \$29.55 85% = \$33.45
69413	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 4 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)	Fee: \$50.65	Benefit: 75% = \$38.00 85% = \$43.10
69415	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of all 5 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PP.7 and PP.13 of explanatory notes to this Category)	Fee: \$61.95	Benefit: 75% = \$46.50 85% = \$52.70
* 69418	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 (Item is subject to rule 25)	Fee: \$64.00	Benefit: 75% = \$48.00 85% = \$54.40
† 69419	A test described in item 69418 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25)	Fee: \$64.00	Benefit: 75% = \$48.00 85% = \$54.40

PATHOLOGY		PATHOLOGY	
‡ 69445	Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69499) - 1 test. To a maximum of 4 of this item in a 12 month period (Item is subject to rule 25)	Fee: \$92.80	Benefit: 75% = \$69.60 85% = \$78.90
† 69451	A test described in item 69445 if rendered by a receiving APP - 1 test. (Item is subject to rule 18 and 25)	Fee: \$92.80	Benefit: 75% = \$69.60 85% = \$78.90
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

PATHOLOGY		PATHOLOGY	
* 69488	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 69499 or 69445) (Item is subject to rule 18 and 25)	Fee: \$181.45	Benefit: 75% = \$136.10 85% = \$154.25
† 69489	A test described in item 69488 if rendered by a receiving APP (Item is subject to rule 18 and 25)	Fee: \$181.45	Benefit: 75% = \$136.10 85% = \$154.25
* 69491	Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if: (a) the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis; and (b) the request for the test is made by, or on the advice of, the specialist or consultant physician managing the treatment of the patient; To a maximum of 1 of this item in a 12 month period	Fee: \$206.20	Benefit: 75% = \$154.65 85% = \$175.30
† 69492	A test described in item 69491 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25)	Fee: \$206.20	Benefit: 75% = \$154.65 85% = \$175.30
* 69494	Detection of a virus or microbial antigen or microbial nucleic acid (not elsewhere specified) 1 test (Item is subject to rule 6 and 26)	Fee: \$28.85	Benefit: 75% = \$21.65 85% = \$24.55
* 69495	2 tests described in 69494 (Item is subject to rule 6 and 26)	Fee: \$36.10	Benefit: 75% = \$27.10 85% = \$30.70
* 69496	3 or more tests described in 69494 (Item is subject to rule 6 and 26)	Fee: \$43.35	Benefit: 75% = \$32.55 85% = \$36.85
† 69497	A test described in item 69494, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6, 18 and 26)	Fee: \$28.85	Benefit: 75% = \$21.65 85% = \$24.55
† 69498	A test described in item 69494, other than that described in 69497, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6, 18 and 26)	Fee: \$7.25	Benefit: 75% = \$5.45 85% = \$6.20
* 69499	Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied: (a) the patient is Hepatitis C seropositive; (b) the patient's serological status is uncertain after testing; (c) the test is performed for the purpose of: (i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or (ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient; To a maximum of 1 of this item in a 12 month period (Item is subject to rule 19 and 25)	Fee: \$92.80	Benefit: 75% = \$69.60 85% = \$78.90
† 69500	A test described in item 69499 if rendered by a receiving APP – 1 test (Item is subject to rule 18,19 and 25)	Fee: \$92.80	Benefit: 75% = \$69.60 85% = \$78.90

PATHOLOGY		PATHOLOGY	
71081	Quantitation of total haemolytic complement Fee: \$41.25 Benefit: 75% = \$30.95 85% = \$35.10		
71083	Quantitation of complement components C3 and C4 or properdin factor B - 1 test Fee: \$20.50 Benefit: 75% = \$15.40 85% = \$17.45		
71085	2 tests described in item 71083 Fee: \$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 (Item is subject to rule 6) Fee: \$29.65 Benefit: 75% = \$22.25 85% = \$25.25		
† 71090	A test described in item 71089, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) Fee: \$29.65 Benefit: 75% = \$22.25 85% = \$25.25		
‡ + 71091	2 tests described in item 71089 (Item is subject to rule 6) Fee: \$53.75 Benefit: 75% = \$40.35 85% = \$45.70		
† 71092	Tests described in item 71089, other than that described in 71090, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18) Fee: \$24.10 Benefit: 75% = \$18.10 85% = \$20.50		
‡ + 71093	3 or more tests described in item 71089 (Item is subject to rule 6) Fee: \$77.75 Benefit: 75% = \$58.35 85% = \$66.10		
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		
† 71096	A test described in item 71095 if rendered by a receiving APP. (Item is subject to rule 18) 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		
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		

PATHOLOGY		PATHOLOGY	
71125	Detection of 4 or more antibodies specified in item 71119 Fee: \$28.15 Benefit: 75% = \$21.15 85% = \$23.95		
71127	Functional tests for lymphocytes - quantitation other than by microscopy of: (a) proliferation induced by 1 or more mitogens; or (b) proliferation induced by 1 or more antigens; or (c) estimation of 1 or more mixed lymphocyte reactions; including a test described in item 65066 or 65070 (if performed), 1 of this item to a maximum of 2 in a 12 month period 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	Quantitation of neutrophil function, comprising at least 2 of the following: (a) chemotaxis; (b) phagocytosis; (c) oxidative metabolism; (d) bactericidal activity; including any test described in items 65066, 65070, 71133 or 71134 (if performed), 1 of this item to a maximum of 2 in a 12 month period 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% = \$367.20		
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 (Item is subject to rule 27) Fee: \$41.25 Benefit: 75% = \$30.95 85% = \$35.10		

PATHOLOGY		PATHOLOGY	
† 71148	A test described in item 71147 if rendered by a receiving APP. (Item is subject to rule 18 and 27) 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		
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 6 and 23) Fee: \$35.15 Benefit: 75% = \$26.40 85% = \$29.90		
† 71154	A test described in item 71153, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test. (Item is subject to rule 6, 18 and 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 6 and 23) Fee: \$48.25 Benefit: 75% = \$36.20 85% = \$41.05		
† 71156	Tests described in item 71153, other than that described in 71154, if rendered by a receiving APP – each test to a maximum of 3 tests (Item is subject to rule 6, 18 and 23) Fee: \$13.10 Benefit: 75% = \$9.85 85% = \$11.15		
‡ 71157	Detection of 3 antibodies described in item 71153 (Item is subject to rule 6 and 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 6 and 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; - 1 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		
‡ * 71165	Antibodies to tissue antigens (acetylcholine receptor, adrenal cortex, 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 (Item is subject to rule 6) Fee: \$35.15 Benefit: 75% = \$26.40 85% = \$29.90		
* 71166	Detection of 2 antibodies described in item 71165 (Item is subject to rule 6) Fee: \$48.25 Benefit: 75% = \$36.20 85% = \$41.05		
* 71167	Detection of 3 antibodies described in item 71165 (Item is subject to rule 6) Fee: \$61.35 Benefit: 75% = \$46.05 85% = \$52.15		

PATHOLOGY		PATHOLOGY	
* 71168	Detection of 4 or more antibodies described in item 71165 (Item is subject to rule 6)	Fee: \$74.45	Benefit: 75% = \$55.85 85% = \$63.30
† 71169	A test described in item 71165, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP – 1 test (Item is subject to rule 6 and 18)	Fee: \$35.15	Benefit: 75% = \$26.40 85% = \$29.90
† 71170	Tests described in item 71165, other than that described in 71169, if rendered by a receiving APP - each test to a maximum of 3 tests (Item is subject to rule 6 and 18)	Fee: \$13.10	Benefit: 75% = \$9.85 85% = \$11.15
† 71180	Antibody to cardiolipin or beta-2 glycoprotein I – detection, including quantitation if required; one antibody specificity (IgG or IgM)	Fee: \$35.15	Benefit: 75% = \$26.40 85% = \$29.90
† 71183	Detection of two antibodies described in item 71180	Fee: \$48.25	Benefit: 75% = \$36.20 85% = \$41.05
† 71186	Detection of three or more antibodies described in item 71180	Fee: \$61.35	Benefit: 75% = \$46.05 85% = \$52.15
† 71189	Detection of specific IgG antibodies to 1 or more respiratory disease allergens not elsewhere specified.	Fee: \$15.75	Benefit: 75% = \$11.85 85% = \$13.40
† 71192	2 items described in item 71189.	Fee: \$28.85	Benefit: 75% = \$21.65 85% = \$24.55
† 71195	3 or more items described in item 71189.	Fee: \$40.75	Benefit: 75% = \$30.60 85% = \$34.65
† 71198	Estimation of serum tryptase for the evaluation of unexplained acute hypotension or suspected anaphylactic event, assessment of risk in stinging insect anaphylaxis, exclusion of mastocytosis, monitoring of known mastocytosis.	Fee: \$41.25	Benefit: 75% = \$30.95 85% = \$35.10
† 71200	Detection and quantitation, if present, of free kappa or lambda light chains in serum for the diagnosis or monitoring of amyloidosis, myeloma or plasma cell dyscrasias.	Fee: \$36.30	Benefit: 75% = \$27.25 85% = \$30.90
† 71203	Determination of HLAB5701 status by flow cytometry or cytotoxicity assay prior to the initiation of Abacavir therapy including item 73323 if performed.	Fee: \$41.25	Benefit: 75% = \$30.95 85% = \$35.10

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>
† 72838	<p>Examination of complexity level 7 biopsy material with multiple 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: \$393.85 Benefit: 75% = \$295.40 85% = \$334.80</p>

PATHOLOGY		PATHOLOGY	
72844	Enzyme histochemistry of skeletal muscle for investigation of primary degenerative or metabolic muscle diseases or of muscle abnormalities secondary to disease of the central or peripheral nervous system - 1 or more tests Fee: \$30.95	Benefit: 75% = \$23.25	85% = \$26.35
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**

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
† 73321	A test described in item 73320, if rendered by a receiving APP - 1 or more tests. (Item is subject to rule 18 and 27) Fee: \$41.25 Benefit: 75% = \$30.95 85% = \$35.10
† 73323	Determination of HLAB5701 status by molecular techniques or cytotoxicity assay prior to the initiation of Abacavir therapy including item 71203 if performed. Fee: \$41.25 Benefit: 75% = \$30.95 85% = \$35.10

PATHOLOGY		PATHOLOGY	
* 73934	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 and 73926) 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. Unless 73935 applies	Fee: \$17.70	Benefit: 75% = \$13.30 85% = \$15.05
† 73935	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in a residential aged care home or institution	Fee: \$2.40	Benefit: 75% = \$1.80 85% = \$2.05
* 73936	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected from the person by the person.	Fee: \$9.80	Benefit: 75% = \$7.35 85% = \$8.35
† 73937	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected from the person by the person and if: (iii) the service is performed in a prescribed laboratory or (iv) the person is a private patient in a recognised hospital	Fee: \$2.40	Benefit: 75% = \$1.80 85% = \$2.05
* 73938	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by or on behalf of the treating practitioner. Unless item 73939 applies	Fee: \$9.80	Benefit: 75% = \$7.35 85% = \$8.35
† 73939	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected by or on behalf of the treating practitioner and if: (v) the service is performed in a prescribed laboratory or (vi) the person is a private patient in a recognised hospital	Fee: \$2.40	Benefit: 75% = \$1.80 85% = \$2.05

PATHOLOGY	PATHOLOGY
GROUP P11 - SPECIMEN REFERRED	
* 73940	<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>

GROUP P12 - MANAGEMENT OF BULK-BILLED SERVICES

74990	<p>A pathology service to which an item in this table (other than this item or item 74991) 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; 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 PP.13 of explanatory notes to this Category)</i></p> <p>Fee: \$6.35 Benefit: 85% = \$5.40</p>
74991	<p>A pathology service to which an item in this table (other than this item or item 74990) 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; 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 PP.13 of explanatory notes to this Category)</i></p> <p>Fee: \$9.60 Benefit: 85% = \$8.20</p>

**INDEX TO
PATHOLOGY SERVICES
(ABBREVIATIONS)**

PART FOUR – INDEX TO PATHOLOGY SERVICES (ABBREVIATIONS)

Abnormal haemoglobins	AH	65117
Acid phosphatase	ACP	66500
Acetoacetate	ACAT	66500
Acetylcholine receptor - tissue antigens - antibodies	ARA	71109
Actinomycetes - microbial antibody testing	ACT	69384
Activated Protein C resistance	APC	65132-136, 65142, 65171
Adenovirus - microbial antibody testing	ADE	69384
Adrenal cortex - tissue antigens - antibodies	ADR	71109
Adrenocorticotrophic hormone (ACTH)	ACTH	66695
AFB microscopy & culture of sputum - 1 specimen	AFB1	69324
AFB microscopy & culture of sputum - 2 specimens	AFB2	69327
AFB microscopy & culture of sputum - 3 specimens	AFB3	69330
Alanine aminotransferase	ALT	66500
Albumin	ALB	66500
Alcohol (ethanol)	ETOH	66626, 66800
Aldosterone	ALDS	66695
Alkaline phosphatase	ALP	66500
Alkaline phosphatase - isoenzymes	ALPI	66641
Alpha-1-antitrypsin	AAT	66635
Alpha-fetoprotein	AFP	66650-53, 66740-43
Aluminium	AL	66672-73
Aluminium - renal dialysis	ALR	66671
Amino acids	AA	66752
Amiodarone	AMIO	66812
Amitriptyline	AMIT	66812
Amikacin		66800
Ammonia	NH3	66500
Amniotic fluid examination	AFE	66749
Amylase	AMS	66500
Amylobarbitone	AMYL	66812
Androstenedione	ANDR	66695
Angiotensin converting enzyme	ACE	66758
Antibiotic & antimicrobial chemotherapeutic agents - quantitation	QAA	66800, 66812
Antibodies to extractable nuclear antigens - characterisation of antibodies if positive ENA	ENAP	71103
Antibodies to extractable nuclear antigens - detection	ENA	71101
Antibodies to nuclear antigens - detection	ANA	71097
Antibodies to nuclear antigens - quantitation & measurement of DNA binding if positive ANA	ANAP	71099
Antibodies to tissue antigens - acetylcholine receptor	ARA	71109
Antibodies to tissue antigens - adrenal cortex	ADR	71109
Antibodies to tissue antigens - ANCA - myeloperoxidase	MPO	71153
Antibodies to tissue antigens - ANCA - PR3	PR3	71153
Antibodies to tissue antigens - anti - actin	AACT	71119
Antibodies to tissue antigens - anti - endomysial	EMA	71163
Antibodies to tissue antigens - cardiolipin	ACL	71109
Antibodies to tissue antigens - coeliac disease panel	CLC	71163-64
Antibodies to tissue antigens - gastric parietal cell	PCA	71119
Antibodies to tissue antigens - gliadin IgA	GLIA	71163
Antibodies to tissue antigens - gliadin IgG	GLIG	71163
Antibodies to tissue antigens - glomerular basement membrane	GBM	71153
Antibodies to tissue antigens - heart	AHE	71109
Antibodies to tissue antigens - histone	AHI	71109
Antibodies to tissue antigens - insulin receptor antibodies	INSA	71109
Antibodies to tissue antigens - intercellular cement substance of skin	ICCS	71109
Antibodies to tissue antigens - intrinsic factor	AIF	71109

Antibodies to tissue antigens - islet cell	AIC	71109
Antibodies to tissue antigens - Jo-1	JO1	71119
Antibodies to tissue antigens - keratin	KERA	71119
Antibodies to tissue antigens - liver/kidney microsomes	LKA	71119
Antibodies to tissue antigens - lymphocyte	ALY	71109
Antibodies to tissue antigens - mitochondria	MA	71119
Antibodies to tissue antigens - neuron	ANE	71109
Antibodies to tissue antigens - neutrophil cytoplasm	ANCA	71153
Antibodies to tissue antigens - ovary	AOV	71109
Antibodies to tissue antigens - parathyroid	PTHA	71109
Antibodies to tissue antigens - platelet	APA	71109
Antibodies to tissue antigens - PM-Sc1	PM1	71119
Antibodies to tissue antigens - reticulin	RCA	71119
Antibodies to tissue antigens - salivary gland	ASG	71109
Antibodies to tissue antigens - Scl-70	SCL	71119
Antibodies to tissue antigens - skeletal muscle	SLA	71109
Antibodies to tissue antigens - skin basement membrane	SKA	71109
Antibodies to tissue antigens - smooth muscle	SMA	71119
Antibodies to tissue antigens - thyroglobulin	ATG	71109
Antibodies to tissue antigens - thyroid microsome	TMA	71109
Antibodies to tissue antigens - tissue transglutaminase	TTG	71163
Antibodies to tissue antigens - TSH receptor antibody test	TSHA	71109
Antibody testing, microbial (see Microbial)		
Antibody to cardiolipin or beta 2 glycoprotein	ACB	71180
Antigen testing, microbial (see Microbial)		
Antithrombin III	ATH	65132-136, 65142, 65171
Anti - Xa activity	QAXA	65147
Anus - cytology on specimens from	SMCY	73043
Apolipoprotein B/A1 ratio	APO	66536
Arsenic	AS	66672-73
Aspartate aminotransferase	AST	66500
Aspergillus - microbial antibody testing	ASP	69384
Avian precipitins (bird fancier's disease) - microbial antibody testing	APP	69384
B12 vitamin	B12	66599
Barbiturate	BARB	66800, 66812
Beryllium	BE	66672-73
Beta-2-microglobulin	BMIC	66629
Beta-hydroxybutyrate	BHYB	66500
Bicarbonate	HCO3	66500
Bilirubin (all fractions)	BILI	66500
Bilirubin (all fractions) - in urine	UBIL	66500
Bilirubin (all fractions) - neonatal	BILN	66749
Bird fancier's disease (see avian precipitins)	APP	69384
Blastomyces - microbial antibody testing	BLM	69384
Blood - compatibility testing	XMAT	65099-108
Blood - culture	BC	69354-60
Blood - faecal occult	FOB	66764-70
Blood - film	BF	65066
Blood - full examination	FBE	65070
Blood - gas	GAS	66566
Blood - group & blood group antibodies	BGAB	65096
Blood - group antibodies	BGA	65111
Blood - group systems	BGS	65093
Blood - grouping - ABO & RH (D antigen)	BG	65090
Blood - viscosity	VISC	65060
Body cavities - aspirations of - microscopy & culture of material from	MCPO	69321
Body fluids - cytology	BFCY	73045
Bone - low mineral densities	CBLB	66773
Bone - metabolic bone disease	CBMB	66776

Bone marrow examination - aspirate	BMEA	65087
Bone marrow examination - trephine	BMET	65084
Bordetella pertussis - microbial antibody testing	BOR	69384
Borrelia burgdorferi - microbial antibody testing	BOB	69384
Breath hydrogen test	BHT	66674
Bromide	BRMD	66812
Brucella - microbial antibody testing	BRU	69384
C-1 esterase inhibitor - functional	CEIF	66647
C-1 esterase inhibitor - quantitation	CEIQ	66644
CA-125 antigen	C125	66650
CA-15.3 antigen	CA15	66650
CA-19.9 antigen	CA19	66650
Cadmium	CD	66672-73
Caeruloplasmin	CPLS	66632
Calcitonin	CALT	66695
Calcium - ionised	ICA	66584
Calcium (total or corrected for albumin)	CA	66500
Calculus analysis	CALC	66590
Campylobacter jejuni - microbial antibody testing	CAM	69384
Candida - microbial antibody testing	CAN	69384
Carbamazepine (Tegretol)	CARB	66800
Carboxyhaemoglobin	COHB	65117
Carcinoembryonic antigen	CEA	66650
Cardiac enzymes (see test groups at para PQ.4)	CE	66506
Cardiolipin - tissue antigens - antibodies	ACL	71109
Catecholamines	CAT	66779
Cell mediated immunity - delayed type - hypersensitivity test	CMI	71137
Cell-mediated immunity in blood	CMIB	69471
Cervix - cytology - abnormalities	CCRA	73055
Cervix - cytology - routine	CCR	73053
Cervix - microscopy & culture of material from	MCGR	69312
Characterisation of antibodies if positive ENA	ENAP	71103
Chemicals, toxic (ingested or absorbed) - assays	DRGO	66623
Chlamydia by any method and N. gonorrhoea by NAA methods	CHGO	69364
Chlamydia - investigation by any method	CHLM	69364
Chlamydia - microbial antibody testing	CHL	69384
Chlamydia - microbial antigen testing	MCCH	69364
Chloral hydrate	CHHY	66812
Chlorazepate	CHZP	66812
Chloride	CL	66500
Chloroquine	CLOQ	66812
Chlorpromazine	CHLO	66812
Cholesterol	CHOL	66500
Cholesterol - HDL	HDLC	66536
Cholinesterase	CHSE	66758
Chorionic gonadotrophin – quantitation	HCG	66650-53, 66740, 73529
Chorionic gonadotrophin – detection for pregnancy diagnosis	HCGP	73527-29
Chromium	CR	66672-73
Chromosome identification - studies - blood	CSB	73289
Chromosome identification - studies - other than blood	CS	73287
Chromosome identification and banding		73287-89
Cimetidine	CMTD	66812
Clobazam	CLOB	66812
Clomipramine	CLOM	66812
Clonazepam (Rivotril)	CLON	66812
Clostridium difficile - microbial antigen testing	CLDT	69363
Coagulation factor inhibitors by Bethesda assay	BETH	65159
Coagulation - factors (see individual factors)		
Coagulation - studies (see test groups at para PQ.4)	COAG	65120

Coccidioides - microbial antibody testing	CCC	69384
Coeliac antibodies	CLC	71163-64
Cold agglutinins	CAG	65114
Collagen - low bone	CBLB	66773
Collagen - metabolic disease	CBMB	66776
Compatability testing	XMAT	65099-108
Complement, total haemolytic	COM	71081
Complement, total haemolytic - components C3	C3	71083
Complement, total haemolytic - components C4	C4	71083
Complement, total haemolytic - other components	COMP	71089
Complement, total haemolytic - properdin factor B	PFB	71083
Copper	CU	66669-70
Cortisol	CORT	66695
Cortisol in saliva	CORS	66711-12
Coxsackie B1-6 - microbial antibody testing	COX	69384
C-Peptide	CPEP	66695
C-reactive protein	CRP	66500
Creatine kinase	CK	66500
Creatine kinase - isoenzymes	CKI	66518
Creatine kinase - isoenzymes (electrophoresis)	CKIE	66518
Creatinine	C	66500
Cryofibrinogen – detection and quantitation	CFID	71064
Cryoglobulins – characterisation by electrophoresis, and immunoelectrophoresis or immunofixation or isoelectric focussing	RYO	71059
Cryoglobulins – detection and quantitation	CGLD	71064
Cryptococcal antigen - microbial antigen testing	CRYN	69364
Cryptococcus - microbial antibody testing	CRY	69384
CSF - microscopy & culture of material from	MCPO	69321
CSF antigens - group B streptococcus	STB	69364
CSF antigens - Haemophilus influenzae	HI	69364
CSF antigens - Neisseria meningitidis	NMG	69364
CSF antigens - Streptococcus pneumoniae	SPN	69364
Cultural examination of faeces	FCS	69345-51
Cyclic AMP	CAMP	66695
Cyclosporin A	CLSA	66812
Cystine - qualitative	UCYS	66752
Cystine - quantitative	CYST	66752
Cytology - fine needle aspiration of solid tissues	FNCY	73049
Cytology - fine needle aspiration of solid tissues - aspiration or attendance by a pathologist	FNCP	73051
Cytology - from 3 sputum or urine specimens	SPCY	73047
Cytology - from body fluids, sputum (1 specimen), urine, washings or brushings	BFCY	73045
Cytology - from cervix - abnormalities	CCRA	73055
Cytology - from cervix - routine	CCR	73053
Cytology - from skin, nipple discharge, lip, mouth, nose or anus	SMCY	73043
Cytology - from vagina	CVO	73057
Cytomegalovirus - microbial antibody testing	CMV	69384
Cytomegalovirus serology in pregnancy - microbial antibody testing	CMVP	69405-11
D vitamin	VITD	66608
D-dimer test	DD	65120
Dehydroepiandrosterone sulphate (DHEAS)	DHEA	66695
Dengue - microbial antibody testing	DEN	69384
11 - Deoxycortisol	DCOR	66695
Desipramine	DESI	66812
Dexamethasone	DXST	66686
Dexamethasone - suppression test	DEXA	66686
DHEAS (Dehydroepiandrosterone sulphate)	DHEA	66695
Diazepam	DIAZ	66812
Differential cell count	DIFF	65070
Digoxin	DIG	66800

Dihydrotestosterone	DHTS	66695
Diphenylhydantoin (Dilantin)	DIL	66812
Diphtheria - microbial antibody testing	DIP	69384
Direct Coombs test	CMBS	65114
Disopyramide (Rythmodan)	DISO	66800
DNA binding - quantitation & measurement if positive ANA	ANAP	71099
DNA, (double-stranded DNA) antibody	DSDNA	71099
Donath Landsteiner antibody test	DLAT	65075
Down's syndrome and neural tube defects (see test groups at para PQ.4)	NTDD	66740
Doxepin hydrochloride	DOXE	66812
Drugs - abuse treatment programme - assay	DATP	66626
Drugs - inappropriate dosage - assay	DRGO	66623
Drugs - therapeutic - assay (See individual drugs)		66800, 66812
Drugs not listed must be written in full		
Dynamic function tests	GHSE	66686
Ear - microscopy & culture of material from	MCSW	69303
Echinococcus - microbial antibody testing	ECC	69384
Echis test	ECHI	65120
ECHO-Coxsackie group - microbial antibody testing	ECH	69384
Electrolytes (see test groups at para PQ.4)	E	66509
Electron microscopy of biopsy material	EM	72851-52
Electrophoresis, and immunofixation or immunoelectrophoresis or isoelectric focussing – characterisation of cryoglobulins	RYO	71059
Electrophoresis, and immunofixation or immunoelectrophoresis or isoelectric focussing – characterisation of paraprotein	PPRO	71059
Electrophoresis, to demonstrate - creatine kinase isoenzymes	CKIE	66518
Electrophoresis, to demonstrate - lactate dehydrogenase isoenzymes	LDI	66641
Electrophoresis, to demonstrate - lipoprotein subclasses	LEPG	66539
Electrophoresis – quantitation of paraprotein classes or paraprotein	EPPI	71057-58
Elements (see individual elements)		
Endomysium antibodies	EMA	71163
Entamoeba histolytica - microbial antibody testing	AMO	69384
Enzyme assays of solid tissue or tissues	ENZS	66683
Enzyme histochemistry of skeletal muscle	EHSK	72844
Eosinophil cationic protein	ECP	71095
Epstein Barr virus - microbial antibody testing	EBV	69472, 69474
Erythrocyte - assessment of haemolysis	ERYH	65075
Erythrocyte - assessment of metabolic enzymes	ERYM	65075
Erythrocyte - count	RCC	65070
Erythrocyte - sedimentation rate	ESR	65060
Ethanol (alcohol)	ETOH	66626, 66800
Ethosuximide (Zarontin)	ETHO	66800
Extractable nuclear antigens - detection of antibodies to	ENA	71101
Eye - microscopy & culture of material from	MCSW	69303
Factor II	FII	65150
Factor IX	FIX	65150
Factor V	FV	65150
Factor VII	FVII	65150
Factor VIII	VIII	65150
Factor X	FX	65150
Factor XI	FXI	65150
Factor XII	FXII	65150
Factor XIII	XIII	65150
Factor XIII deficiency test	F13D	65120
Faecal antigen test for Helicobacter pylori	FAHP	69364
Faecal blood	FOB	66764-70
Faecal fat	FFAT	66674
Faecal fat - haemoglobin	FFH	66764
Faecal fat - reducing substances	FRS	66761
Faeces - culture	FCS	69345-51

Faeces - microscopy for parasites	OCP	69336-42
Ferritin (see also Iron studies)	FERR	66593
Fibrin monomer	FM	65120
Fibrinogen	FIB	65120
Fibrinogen - degradation products	FDP	65120
Fitzgerald factor	FGF	65150
Flecainide	FLEC	66812
Fletcher factor	FF	65150
Fluorescent treponemal antibody - absorption test (FTA-ABS) - microbial antibody testing	FTA	69384
Fluoxetine	FLUX	66812
Foetal red blood cells - Kliehauer	KLEI	65162
Folate - red cell	RCF	66599
Follicle stimulating hormone (FSH)	FSH	66695
Fragile X	FXS	73300, 73305
Frozen section diagnosis of biopsy material	FS	72855-56
Fructosamine	FRUC	66557
Full blood examination	FBE	65070
Gamma glutamyl transpeptidase	GGT	66500
Gastric parietal cell - tissue antigens - antibodies	PCA	71119
Gastrin	GAST	66695
Gentamicin		66800
Gliadin antibodies	GLIA	71163
Globulin	GLOB	66500
Glomerular basement membrane - tissue antigens - antibodies	GBA	71109
Glucagon	GLGO	66695
Glucose	GLUC	66500
Glucose - tolerance test	GTT	66542
Glycosylated haemoglobin (Hb Alc)	GHB	66551
Gold	AU	66672-73
Group B streptococcus - CSF antigens	STB	69364
Group B streptococcus - microbial antigen testing	STB	69364
Group P9 - simple basic pathology tests		73801-11
Growth hormone	GH	66695
Growth hormone - stimulation by exercise or L-dopa	GHSE	66686
Growth hormone - suppression by dexamethasone or glucose	GHSG	66686
Haematocrit	HCT	65070
Haemochromatosis	FEUP	66794
Haemoglobin	HB	65060
Haemoglobinopathy tests	HMGP	65081
Haemophilus influenzae - CSF antigens	HI	69364
Haemophilus influenzae - microbial antibody testing	HUS	69384
Haemophilus influenzae - microbial antigen testing	HI	69364
Haloperidol	HALO	66812
Haptoglobins	HGLB	66632
HDL cholesterol	HDLC	66536
Heart - tissue antigens - antibodies	AHE	71109
Heparin - test	HEPR	65144
Hepatitis B or C confirmatory test	HSVP	69484
Hepatitis C - detection	RNAC	69444
Hepatitis C - genotype	GHCV	69443
Hepatitis C - quantitation	THCV	69442
Hepatitis investigation - 3 markers	HEP3	69481
Hepatitis serology - in pregnancy	HEPP	69405-13
Hepatitis status or carriage - 1 marker	HEP1	69475
Hepatitis status or carriage - 2 markers	HEP2	69478
Hepatitis status or carriage - 3 markers	HEP3	69481
Herpes simplex virus - direct detection from clinical material	HSV	69364
Herpes simplex virus - investigation by culture	HSVC	69364
Herpes simplex virus - microbial antibody testing	HPA	69384

Herpes simplex virus - microbial antigen testing	HSV	69364
Heterophil antibodies	IM	65114
HIAA (hydroxyindoleacetic acid)	HIAA	66779
Histamine	HIAM	66779
Histone - tissue antigens - antibodies	AHI	71109
Histopathology of biopsy material	HIST	72813-36
Histoplasma - microbial antibody testing	HIP	69384
HIV - antiretroviral therapy	TVLT	69381
HIV - cerebrospinal fluid	CVLT	69382
HIV - monitoring	MVLT	69378
HLA typing - HLA class 1	HLA1	71149
HLA typing - HLA class 2	HLA2	71151
HLA typing - HLA-B27	HLAB	71147
HLAB5701 – status by flow cytometry or cytotoxicity assay	HLAF	71203
HLAB5701 – status by molecular techniques or cytotoxicity assay	HLAM	73323
HMMA (hydroxy-3-methoxymandelic acid, previously known as VMA)	HMMA	66779
HMPG (hydroxy-methoxy phenylethylene glycol)	HMPG	66779
Homovanillic acid	HVA	66779
Hormones - stimulation by exercise or L-dopa	GHSE	66686
Hormone receptor assay - breast	HRA	66662
Hormone receptor assay - ovary	HRO	66662
Hormones - 11 deoxycortisol	DCOR	66695
Hormones - adrenocorticotrophic hormone	ACTH	66695
Hormones - aldosterone	ALDS	66695
Hormones - androstenedione	ANDR	66695
Hormones - calcitonin	CALT	66695
Hormones - cortisol	CORT	66695
Hormones - C-Peptide	CPEP	66695
Hormones - cyclic AMP	CAMP	66695
Hormones - dehydroepiandrosterone sulphate (DHEAS)	DHEA	66695
Hormones - dihydrotestosterone	DHTS	66695
Hormones - follicle stimulating hormone	FSH	66695
Hormones - gastrin	GAST	66695
Hormones - glucagon	GLGO	66695
Hormones - growth hormone	GH	66695
Hormones - growth hormone - stimulation by exercise or L-dopa	GHSE	66686
Hormones - growth hormone - suppression by dexamethasone or glucose	GHSG	66686
Hormones - hormone receptor assay - breast	HRA	66662
Hormones - hormone receptor assay - ovary	HRO	66662
Hormones - human chorionic gonadotrophin – quantitation	HCG	66650-53, 66740, 73529
Hormones - human chorionic gonadotrophin – detection for pregnancy diagnosis	HCGP	73527, 73529
Hormones - human placental lactogen	HPL	66746
Hormones - hydroxyprogesterone	OHP	66695
Hormones - insulin	INS	66695
Hormones - luteinizing hormone	LH	66695
Hormones - oestradiol	E2	66695
Hormones - oestriol	E3	66740, 66746
Hormones - oestrone	E1	66695
Hormones - parathyroid hormone	PTH	66695
Hormones - progesterone	PROG	66695
Hormones - prolactin	PROL	66695
Hormones - renin	REN	66695
Hormones - sex hormone binding globulin	SHBG	66695
Hormones - somatomedin	SOMA	66695
Hormones - suppression by dexamethasone or glucose	GHSG	66686
Hormones - testosterone	TES	66695
Hormones - urine steroid fraction or fractions	USF	66695
Hormones - vasoactive intestinal peptide	VIP	66695
Hormones - vasopressin	ADH	66695

Hormones & hormone binding proteins (see individual hormones and proteins)		66695
Huhner's test	HT	73521
Human chorionic gonadotrophin - quantitation	HCG	66650-53, 66740, 73529
Human chorionic gonadotrophin – detection for pregnancy diagnosis	HCGP	73527, 73529
Human Papillomaviruses	HPV	69486
Human placental lactogen	HPL	66746
HVA (homovanillic acid)	HVA	66779
Hydatid - microbial antibody testing	HYD	69384
Hydroxy methoxy phenylethylene glycol	HMPG	66779
Hydroxy-3-methoxymandelic acid, previously known as VMA)	HMMA	66779
Hydroxychloroquine	HOCQ	66812
Hydroxyindoleacetic acid	HIAA	66779
Hydroxyprogesterone	OHP	66695
Hydroxyproline	HYDP	66752
Imipramine	IMIP	66812
Immediate frozen section diagnosis of biopsy material	FS	72855-56
Immunocyto. 1-3 antibodies	ICC	73059, 73061
Immunocyto. 4+ antibodies	ICC1	73060
Immunoelectrophoresis and electrophoresis – characterisation of cryoglobulins	RYO	71059
Immunoelectrophoresis and electrophoresis – characterisation of paraprotein	PPRO	71059
Immunoglobulins - A	IGA	71066
Immunoglobulins - D	IGD	71074
Immunoglobulins - E (total)	IGE	71075-79
Immunoglobulins - G	IGG	71068
Immunoglobulins - G, 4 subclasses	SIGG	71073
Immunoglobulins - M	IGM	71072
Immunohistochemical investigation of biopsy material	HIS	72846-48
Infectious mononucleosis	IM	69384
Influenza A - microbial antibody testing	FLA	69384
Influenza B - microbial antibody testing	FLB	69384
Insulin	INS	66695
Insulin - tissue antigens - antibodies	AINS	71109
Insulin receptor antibodies - tissue antigens – antibodies	INSA	71109
Intercellular cement substance of skin - tissue antigens - antibodies	ICCS	71109
Intestinal disaccharidases	INTD	66680
Intrinsic factor - tissue antigens - antibodies	AIF	71109
Iron studies (iron, transferrin & ferritin)	IS	66596
Islet cell - tissue antigens - antibodies	AIC	71109
Isoelectric focussing and electrophoresis – characterisation of cryoglobulins	RYO	71059
Isoelectric focussing and electrophoresis – characterisation of paraprotein	PPRO	71059
Jo-1 - tissue antigens - antibodies	JO1	71119
Keratin - tissue antigens - antibodies	KERA	71119
Kleihauer test	KLEI	65162
Lactate	LACT	66500
Lactate - dehydrogenase	LDH	66500
Lactate - dehydrogenase isoenzymes	LDI	66641
Lamellar body phospholipid	LBPH	66749
Lead	PB	66665
Lecithin/sphingomyelin ratio (amniotic fluid)	LS	66749
Legionella pneumophila - serogroup 1 - microbial antibody testing	LP1	69384
Legionella pneumophila - serogroup 2 - microbial antibody testing	LP2	69384
Leishmaniasis - microbial antibody testing	LEI	69384
Leptospira - microbial antibody testing	LEP	69384
Leucocyte count	WCC	65070
Leucocyte count - CD34 surface marker only - blood	LMCD34	71146
Leucocyte count - 3 surface markers - blood, CSF, serous fluid	LMH3	71139
Leucocyte count - 3 surface markers - tissue	LMT3	71141
Leucocyte count - 6 surface markers - blood, CSF, serous fluid & tissue(s)	LMHT	71145
Leucocyte count - 6 surface markers - blood, CSF, serous fluid or tissue	LM6	71143

Light chains – free kappa or lambda	LCHS	71200
Lignocaine	LIGN	66800
Lip - cytology on specimens from	SMCY	73043
Lipase	LIP	66500
Lipid studies (see test groups at para PQ.4)	FATS	66500
Lipoprotein subclasses - electrophoresis	LEPG	66539
Listeria - microbial antibody testing	LIS	69384
Lithium	LI	66800
Liver function tests (see test groups at para PQ.4)	LFT	66515
Liver/kidney microsomes - tissue antigens - antibodies	LKA	71119
Lupus anticoagulant 65142	LUPA	65132-37,
Luteinizing hormone	LH	66695
Lymphocyte - tissue antigens - antibodies	ALY	71109
Lymphocytes - functional tests - 1 test	LF1	71127
Lymphocytes - functional tests - 2 tests	LF2	71129
Lymphocytes - functional tests - 3 tests	LF3	71131
Magnesium	MG	66500
Mammary serum antigen	MSA	66650
Manganese	MN	66669-70
Mantoux test	MANT	73811
Measles - microbial antibody testing	MEA	69384
Mercury	HG	66672-73
Metabolic bone disease	CBMB	66776
Methaemalbumin detection (Schumm's test)	SCHM	65117
Metanephrines	MNEP	66779
Methadone	MTDN	66812
Methotrexate	MTTA	66812
Methsuximide	MSUX	66812
Methylphenobarbitone	MPBT	66812
Metronidazole	MRDZ	66812
Mexiletine (Mexitil)	MEX	66812
Mianserin	MIAS	66812
Microalbumin	MALB	66560
Microbial antibody testing - actinomycetes	ACT	69384
Microbial antibody testing - adenovirus	ADE	69384
Microbial antibody testing - aspergillus	ASP	69384
Microbial antibody testing - avian precipitins (bird fancier's disease)	APP	69384
Microbial antibody testing - Blastomyces	BLM	69384
Microbial antibody testing - Bordetella pertussis	BOR	69384
Microbial antibody testing - Borrelia burgdorferi	BOB	69384
Microbial antibody testing - Brucella	BRU	69384
Microbial antibody testing - Campylobacter jejuni	CAM	69384
Microbial antibody testing - Candida	CAN	69384
Microbial antibody testing - Chlamydia	CHL	69384
Microbial antibody testing - Coccidioides	CCC	69384
Microbial antibody testing - Coxsackie B1-6	COX	69384
Microbial antibody testing - cryptococcus	CRY	69384
Microbial antibody testing - cytomegalovirus	CMV	69384
Microbial antibody testing - cytomegalovirus serology in pregnancy	CMVP	69384
Microbial antibody testing - dengue	DEN	69384
Microbial antibody testing - diphtheria	DIP	69384
Microbial antibody testing - echinococcus	ECC	69384
Microbial antibody testing - echo-coxsackie group	ECH	69384
Microbial antibody testing - Entamoeba histolytica	AMO	69384
Microbial antibody testing - Epstein Barr virus	EBV	69472, 69474
Microbial antibody testing - fluorescent treponemal antibody - absorption test (FTA-ABS)	FTA	69384
Microbial antibody testing - Haemophilus influenzae	HUS	69384
Microbial antibody testing - herpes simplex virus	HPA	69384

Microbial antibody testing - Histoplasma	HIP	69384
Microbial antibody testing – Human Immunodeficiency Virus		69384
Microbial antibody testing - hydatid	HYD	69384
Microbial antibody testing - infectious mononucleosis	IM	69384
Microbial antibody testing - influenza A	FLA	69384
Microbial antibody testing - influenza B	FLB	69384
Microbial antibody testing - Legionella pneumophila - serogroup 1	LP1	69384
Microbial antibody testing - Legionella pneumophila - serogroup 2	LP2	69384
Microbial antibody testing - leishmaniasis	LEI	69384
Microbial antibody testing - Leptospira	LEP	69384
Microbial antibody testing - Listeria	LIS	69384
Microbial antibody testing - measles	MEA	69384
Microbial antibody testing - Micropolyspora faeni	MIC	69384
Microbial antibody testing - mumps	MUM	69384
Microbial antibody testing - Murray Valley encephalitis	MVE	69384
Microbial antibody testing - Mycoplasma pneumoniae	MYC	69384
Microbial antibody testing - Neisseria meningitidis	MEN	69384
Microbial antibody testing - Newcastle disease	NCD	69384
Microbial antibody testing - parainfluenza 1	PF1	69384
Microbial antibody testing - parainfluenza 2	PF2	69384
Microbial antibody testing - parainfluenza 3	PF3	69384
Microbial antibody testing - paratyphi	PTY	69384
Microbial antibody testing - pertussis	PER	69384
Microbial antibody testing - poliomyelitis	PLO	69384
Microbial antibody testing - Proteus OX 19	POX	69384
Microbial antibody testing - Proteus OXK	POK	69384
Microbial antibody testing - Q fever	QFF	69384
Microbial antibody testing - rapid plasma reagin test	RPR	69384
Microbial antibody testing - respiratory syncytial virus	RSV	69384
Microbial antibody testing - Ross River virus	RRV	69384
Microbial antibody testing - rubella	RUB	69384
Microbial antibody testing - Salmonella typhi (H)	SAH	69384
Microbial antibody testing - Salmonella typhi (O)	SAO	69384
Microbial antibody testing - Schistosoma	STO	69384
Microbial antibody testing - streptococcal serology - anti-DNASE B titre	ADNB	69384
Microbial antibody testing - streptococcal serology - anti-streptolysin O titre	ASOT	69384
Microbial antibody testing - Streptococcus pneumoniae	PCC	69384
Microbial antibody testing - tetanus	TET	69384
Microbial antibody testing - Thermoactinomyces vulgaris	THE	69384
Microbial antibody testing - thermopolyspora	TPS	69384
Microbial antibody testing - Toxocara	TOC	69384
Microbial antibody testing - toxoplasma	TOX	69384
Microbial antibody testing - TPHA (Treponema pallidum haemagglutination test)	TPHA	69384
Microbial antibody testing - Treponema pallidum haemagglutination test	TPHA	69384
Microbial antibody testing - trichinosis	TOS	69384
Microbial antibody testing - typhus, Weil-Felix	TYP	69384
Microbial antibody testing - Varicella zoster	VCZ	69384
Microbial antibody testing - VDRL (Venereal Disease Research Laboratory)	VDRL	69384
Microbial antibody testing - Yersinia enterocolitica	YER	69384
Microbial antigen testing - Chlamydia	MCCH	69364
Microbial antigen testing - Clostridium difficile	CLDT	69363
Microbial antigen testing - group B streptococcus	STB	69364
Microbial antigen testing - Haemophilus influenzae	HI	69364
Microbial antigen testing - herpes simplex virus	HSV	69364
Microbial antigen testing - Neisseria gonorrhoeae	GON	69364
Microbial antigen testing - Neisseria meningitidis	NMG	69364
Microbial antigen testing - respiratory syncytial virus	RSVN	69364
Microbial antigen testing - Streptococcus pneumoniae	SPN	69364
Microbial antigen testing - Varicella zoster	VCZN	69364
Micropolyspora faeni	MIC	69384

Microscopic examination of - faeces for parasites	OCP	69336-42
Microscopy of wet film material other than blood	MWFM	69300
Microscopy & culture of - material from nose, throat, eye or ear	MCSW	69303
Microscopy & culture of - material from skin	MCSK	69309
Microscopy & culture of - postoperative wounds, aspirates of body cavities	MCPO	69321
Microscopy & culture of - superficial sites	MCSS	69306
Microscopy & culture of - urethra, vagina, cervix or rectum	MCGR	69312
Microscopy & culture of - specimens of sputum	MCSP	69318
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 1 specimen	AFB1	69324
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 2 specimens	AFB2	69327
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 3 specimens	AFB3	69330
Microscopy & culture to detect pathogenic micro-organisms including chlamydia	MCCH	69364
Microscopy, culture, identification & sensitivity of urine	UMCS	69333
Mitochondria - tissue antigens - antibodies	MA	71119
Mouth - cytology on specimens from	SMCY	73043
Mumps - microbial antibody testing	MUM	69384
Murray Valley encephalitis - microbial antibody testing	MVE	69384
Mycobacteria microscopy & culture of sputum - 1 specimen	AFB1	69324
Mycobacteria microscopy & culture of sputum - 2 specimens	AFB2	69327
Mycobacteria microscopy & culture of sputum - 3 specimens	AFB3	69330
Mycoplasma pneumoniae - microbial antibody testing	MYC	69384
Myoglobin	MYOG	66518
N-acetyl procainamide	NAPC	66812
Neisseria gonorrhoeae by NAA techniques and chlamydia by any method	CHGO	69364
Neisseria gonorrhoeae - microbial antigen testing	GON	69364
Neisseria meningitidis - antigens	NMG	69364
Neisseria meningitidis - microbial antibody testing	MEN	69384
Neisseria meningitidis - microbial antigen testing	NMG	69364
Netilmicin		66800
Neural tube defects and Down's syndrome	NTDD	66740
Neuron - tissue antigens - antibodies	ANE	71109
Neutrophil cytoplasm - tissue antigens - antibodies	ANCA	71109
Neutrophil functions	NFT	71135
Newcastle disease - microbial antibody testing	NCD	69384
Nickel	NI	66672-73
Nipple discharge - cytology on specimens from	SMCY	73043
Nitrazepam	NITR	66812
Nordothiepin	NDIP	66812
Norfluoxetine	NFLE	66812
Nortriptyline	NORT	66812
Nose - cytology on specimens from	SMCY	73043
Nose - microscopy & culture of material from	MCSW	69303
Nuclear antigens - detection of antibodies to	ANA	71097
Oestradiol	E2	66695
Oestriol	E3	66740, 66746
Oestrone	E1	66695
Oligoclonal proteins	OGP	71062
Op/biopsy specimens - microscopy & culture of material from	MCPO	69321
Oral glucose challenge test - gestational diabetes	OGCT	66545
Oral glucose tolerance test - gestational diabetes	GTTP	66542
Osmolality, serum or urine	OSML	66563
Ovary - tissue antigens - antibodies	AOV	71109
Oxalate	OXAL	66752
Oxazepam	OXAZ	66812
PAA (phenyl acetic acid)	PAA	66779
Palmitic acid in amniotic fluid	PALM	66749
Pap smear	CCR	73053

Papanicolaou test	CCR	73053
Paracetamol	PARA	66800
Parainfluenza 1 - microbial antibody testing	PF1	69384
Parainfluenza 2 - microbial antibody testing	PF2	69384
Parainfluenza 3 - microbial antibody testing	PF3	69384
Paraprotein characterisation - by electrophoresis, and immunoelectrophoresis or immunofixation or isoelectric focussing	PPRO	71059
Paraprotein quantitation - by electrophoresis	EPPI	71057
Paraprotein characterisation - on concurrently collected serum or urine	PPSU	71060
Paraquat	PARQ	66812
Parasites - microscopic examination of faeces	OCP	69336-42
Parathyroid - tissue antigens - antibodies	PTHA	71109
Parathyroid hormone (PTH)	PTH	66695
Paratyphi - microbial antibody testing	PTY	69384
Partial thromboplastin time	PTT	65120
Patient episode initiation fees	PEI	73901-15
Pentobarbitone	PENT	66812
Perhexiline	PHEX	66812
Pertussis - microbial antibody testing	PER	69384
Phenobarbitone	PHBA	66800
Phensuximide	PHEN	66812
Phenylacetic acid	PAA	66779
Phenytoin	PHEY	66800
Phosphate	PHOS	66500
Phosphatidylglycerol	PTGL	66749
Platelet - tissue antigens - antibodies	APA	71109
Platelet - aggregation	PLTG	65144
Platelet - count	PLTC	65070
PM-Sc1 - tissue antigens - antibodies	PM1	71119
Poliomyelitis - microbial antibody testing	PLO	69384
Porphobilinogen in urine	UPG	66782
Porphyryns - quantitative test, 1 or more fractions	PR	66785
Porphyryns in urine - qualitative test	UPR	66782
Potassium	K	66500
Prealbumin	PALB	66632
Prednisolone	PRED	66812
Pregnancy serology - 1 test	MSP1	69405
Pregnancy serology - 2 tests	MSP2	69408
Pregnancy serology - 3 tests	MSP3	69411
Pregnancy serology - 4 tests	MSP4	69413
Pregnancy testing		73806
Prenancy testing – bile acids in blood	BABP	66517
Pregnancy testing – HCG detection	HCGP	73527,73529
Pregnancy testing - diagnosis of Down's syndrome and neural tube defect (see tests groups at para PQ.4)	NTDD	66740
Pregnancy testing – HCG quantitation	HCG	73529
Primidone	PRIM	66800
Procainamide	PCAM	66800
Progesterone	PROG	66695
Prolactin	PROL	66695
Propranolol	PPNO	66812
Prostate specific antigen	PSA	66655-66659
Protein C	PROC	65132-36, 65142, 65171
Protein S	PROS	65132-36, 65142, 65171
Protein, quantitation of - alpha fetoprotein	AFP	66650-53, 66740, 66743
Protein, quantitation of - alpha-1-antitrypsin	AAT	66635

Protein, quantitation of - beta-2-microglobulin	BMIC	66629
Protein, quantitation of - caeruloplasmin	CPLS	66632
Protein, quantitation of - C-1 esterase inhibitor	CEI	66644
Protein, quantitation of - classes or presence and amount of paraprotein by electrophoresis	EPPI	71057-71058
Protein, quantitation of - ferritin (see also Iron studies)	FERR	66593
Protein, quantitation of - for Down's syndrome/neural tube defect testing	NTDD	66740
Protein, quantitation of - haptoglobins	HGLB	66632
Protein, quantitation of - microalbumin	MALB	66560
Protein, total - quantitation of	PROT	66500
Proteus OX 19 - microbial antibody testing	POX	69384
Proteus OXK - microbial antibody testing	POK	69384
Prothrombin time	PT	65120
Pyruvate	PVTE	66500
Q fever - microbial antibody testing	QFF	69384
Quinalbarbitone	QUIB	66812
Quinidine	QUIN	66800
Quinine	QNN	66812
Rapid plasma reagin test - microbial antibody testing	RPR	69384
RAST	RAST	71079
Rectum - microscopy & culture of material from	MCGR	69312
Red blood cells - Kleihauer	KLEI	65162
Red cell folate & serum B12	B12F	66602
Red cell folate & serum B12 & serum folate if required	B12F	66602
Red cell folate and serum folate	RCF	66599
Red cell porphyrins - qualitative test	RCP	66782
Referred specimen fee		73921
Renin	REN	66695
Reptilase test	REPT	65120
Respiratory syncytial virus - microbial antibody testing	RSV	69384
Respiratory syncytial virus - microbial antigen testing	RSVN	69364
Reticulin - tissue antigens - antibodies	RCA	71119
Reticulocyte count	RETC	65072
Rheumatoid factor	RF	71106
Rheumatoid factor - quantitation	RFQ	71106
Ross River virus - microbial antibody testing	RRV	69384
RSV (respiratory syncytial virus) - microbial antibody testing	RSV	69384
RSV (respiratory syncytial virus) - microbial antigen testing	RSVN	69364
Rubella - serology	RUB	69384
Salicylate (aspirin)	SALI	66800
Salivary gland - tissue antigens - antibodies	ASG	71109
Salmonella typhi (H) - microbial antibody testing	SAH	69384
Salmonella typhi (O) - microbial antibody testing	SAO	69384
Schistosoma - microbial antibody testing	STO	69384
Scl-70 - tissue antigens - antibodies	SCL	71119
Selenium	SE	66669-70
Semen examination	SEE	73523
Semen examination - for spermatozoa (post vasectomy)	SES	73521
Serology - in pregnancy (see Pregnancy serology)		
Serotonin	5HT	66779
Serum - B12	B12	66599
Serum - folate (with B12 red cell folate)	B12F	66602
Serum - folate (with B12)	B12	66599
Sex hormone binding globulin	SHBG	66695
Skeletal muscle - tissue antigens - antibodies	SLA	71109
Skin - cytology	SMCY	73043
Skin - microscopy & culture of material from	MCSS	69306
Skin - microscopy, culture & Chlamydia of material from	MCSK	69309
Skin basement membrane - tissue antigens - antibodies	SKA	71109
Smooth muscle - tissue antigens - antibodies	SMA	71119

Snake venom	HISS	66623
Sodium	NA	66500
Solid tissue or tissues - chemical assays	ENZS	66683
Solid tissue or tissues - cytology of fine needle aspiration	FNCY	73049
Solid tissue or tissues - cytology of fine needle aspiration by, or in presence of pathologist	FNCP	73051
Somatomedin	SOMA	66695
Sotalol	SALL	66812
Specific IgC antibodies – respiratory disease allergens	RDA	71189
Specific IgG or IgE antibodies	RAST	71079
Specimen dissection – level 7	SPE7	72838
Specimen referred fee		73921
Sperm antibodies	SAB	73525
Sperm antibodies - penetrating ability	SPA	73525
Sputum - cytology (1 specimen)	BFCY	73045
Sputum - cytology (3 specimens)	SPCY	73047
Sputum - for mycobacteria - 1 specimen	AFB1	69324
Sputum - for mycobacteria - 2 specimens	AFB2	69327
Sputum - for mycobacteria - 3 specimens	AFB3	69330
Sputum - microscopy & culture of specimens	MCSP	69318
Stelazine	STEL	66812
Steroid fraction or fractions in urine	USF	66695
Streptococcal serology - anti-DNASE B titre - microbial antibody testing	ADNB	69384
Streptococcal serology - anti-streptolysin O titre - microbial antibody testing	ASOT	69384
Streptococcus - Group B	STB	69364
Streptococcus pneumoniae - CSF antigens	SPN	69364
Streptococcus pneumoniae - microbial antibody testing	PCC	69384
Streptococcus pneumoniae - microbial antigen testing	SPN	69364
Strontium	SR	66672-73
Stypven test	STYP	65120
Sugar water test	SWT	65075
Sulthiame (Ospolot)	SUL	66812
Supplementary testing for Hepatitis C antibodies	HCST	69441
Syphilis serology (see test groups at para PQ.4)	STS	69387
Testosterone	TES	66695
Tetanus - microbial antibody testing	TET	69384
Thalassaemia studies	TS	65078
Theophylline	THEO	66800
Thermoactinomyces vulgaris - microbial antibody testing	THE	69384
Thermopolyspora - microbial antibody testing	TPS	69384
Thiopentone	TOPO	66812
Thioridazine	THIO	66812
Throat - microscopy & culture of material from	MCSW	69303
Thrombin time	TT	65120
Thrombophilia testing – see individual thrombophilia tests		
Thyroglobulin	TGL	66650
Thyroglobulin - tissue antigens - antibodies	ATG	71109
Thyroid function tests (including TSH)	TFT	66719
Thyroid microsome - tissue antigens - antibodies	TMA	71109
Thyroid stimulating hormone (if requested on its own, or as a preliminary test to thyroid function testing)	TSH	66716
Thyroid stimulating hormone (if requested with other hormones referred to in item 66695)	TSH	66722-34
Tissue transglutaminase antibodies	TTG	71163
Tobramicin		66800
Total protein	PROT	66500
Toxocara - microbial antibody testing	TOC	69384
Toxoplasma - microbial antibody testing	TOX	69384
TPHA (Treponema pallidum haemagglutination test) - microbial antibody testing	TPHA	69384

Treponema pallidum haemagglutination test - microbial antibody testing	TPHA	69384
Trichinosis - microbial antibody testing	TOS	69384
Triglycerides	TRIG	66500
Trimipramine	TRIM	66812
Troponin	TROP	66518
Tryptase – serum	TRYP	71198
Tryptic activity in faeces	TAF	66677
TSH receptor antibody test - tissue antigens - antibodies	TSHA	71109
Tuberculosis	MANT	73811
Tumour markers - CA-125 antigen	C125	66650
Tumour markers - CA-15.3 antigen	CA15	66650
Tumour markers - CA-19.9 antigen	CA19	66650
Tumour markers - carcinoembryonic antigen	CEA	66650
Tumour markers - mammary serum antigen	MSA	66650
Tumour markers - prostate specific antigen	PSA	66656
Tumour markers - prostatic acid phosphatase - 1 or more fractions	ACP	66656
Tumour markers - thyroglobulin	TGL	66650
Typhus, Weil-Felix - microbial antibody testing	TYP	69384
Urate	URAT	66500
Urea	U	66500
Urea, electrolytes, creatinine (see test groups at para PQ.4)	U&E	66515
Urethra - microscopy & culture of material from	MCGR	69312
Urine - acidification test	UAT	66587
Urine - catalase test	UCAT	73805
Urine - cystine (cysteine)	UCYS	66782
Urine - cytology - on 1 specimen	BFCY	73045
Urine - cytology - on 3 specimens	SPCY	73047
Urine - haemoglobin	UHB	66782
Urine - microscopy, culture, identification & sensitivity	UMCS	69333
Urine - porphobilinogen	UPG	66782
Urine - porphyrins - qualitative test	UPR	66782
Urine - steroid fraction or fractions	USF	66695
Urine - urobilinogen	UUB	66782
Vagina - microscopy & culture of material from	MCGR	69312
Vagina - cytology on specimens from	CVO	73057
Valproate (Epilim)	VALP	66800
Vancomycin	VAN	66800
Varicella zoster - microbial antibody testing	VCZ	69384
Varicella zoster - microbial antigen testing	VCZN	69364
Vasoactive intestinal peptide	VIP	66695
Vasopressin	ADH	66695
VDRL (Venereal Disease Research Laboratory) - microbial antibody testing	VDRL	69384
Viscosity of blood or plasma	VISC	65060
Vitamins - B12	B12	66599
Vitamins - D	VITD	66608
Vitamins - folate	RCF	66599
Vitamins - quantitation of A, B1, B2, B3, B6, C or E	VIT	66605
VMA (see HMMA)		
Von Willebrand's factor	VWF	65150
Von Willebrand's factor antigen	VWA	65150
Warfarin	WFR	66812
Yersinia enterocolitica - microbial antibody testing	YER	69384
Zinc	ZN	66667-70

PART FIVE - COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

Specimen Type	Complexity Level
Adrenal resection, neoplasm	5
Adrenal resection, not neoplasm	4
Anus, all specimens not otherwise specified	3
Anus, neoplasm, biopsy	4
Anus, neoplasm, radical resection	6
Anus, submucosal resection – neoplasm	5
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 – microdochoectomy	6
Breast, orientated wide local excision for carcinoma, weighing at least 70g, with margin assessment	7
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
Large bowel (including rectum), submucosal resection – neoplasm	5
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
Oesophagus, submucosal resection – neoplasm	5
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 prostatectomy or cystoprostatectomy for carcinoma	7
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
Small bowel, submucosal resection – neoplasm	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, submucosal resection – neoplasm	5
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

OUTLINE OF CLEFT LIP AND CLEFT PALATE SCHEME AND NOTES FOR GUIDANCE

CA. INTRODUCTION

CA.1 Medicare Benefits

CA.1.1 The Medicare Benefits Schedule includes certain professional services in respect of the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable. These services are normally described as dental services. However, for the purposes of these Notes the word "medical" is to be interpreted to include "dental". The definition of professional service as contained in the Health Insurance Act provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

CA.1.2 Medicare benefits are payable in respect of services listed in the Schedule (contained in Section 2 of this booklet), when the services are rendered by eligible dental practitioners to prescribed dental patients (see paragraph CC).

CA.1.3 The Schedule lists three categories of professional services:

- Group C1 Orthodontic Services
- Group C2 Oral and Maxillofacial Surgical Services
- Group C3 General and Prosthodontic Services

CB. DENTAL PRACTITIONER ELIGIBILITY

CB.1 Eligible Practitioners

CB.1.1 In order to attract Medicare benefits, all treatment must be carried out by eligible dental practitioners who are resident in Australia. Practitioner eligibility is covered under the provisions of Subsection 3(1) of the Health Insurance Act 1973.

CB.1.2 All State registered dental practitioners are entitled to perform simple extraction services covered by Items 75200-75206 listed in Group C2 of the Schedule (see paragraph CG.6 of these notes) and the general and prosthodontic services listed in Group C3 of the Schedule. Practitioners do not need to apply for accreditation or approval to perform these services.

CB.1.3 Dental practitioners who wish to be accredited for the purposes of Subsection 3(1) of the Act to perform those orthodontic services listed in Group C1 of the Schedule must submit an application for consideration by the Medical Benefits (Dental Practitioners) Advisory Committee. This Committee will recommend to the Minister the names of those dental practitioners who, in its opinion, should be accredited by the Minister to provide orthodontic services.

CB.1.4 The criteria used in granting accreditation for orthodontic services are that the dental practitioner is a practitioner who is either -

- registered by one of the State Dental Boards as an orthodontist; or
- can substantiate by qualifications and experience a level of competence in the field of orthodontics equivalent to the above criterion.

CB.1.5 Dental practitioners holding the FRACDS (OMS) or equivalent who were approved by the Minister prior to 1 November 2004 for the purposes of Subsection 3 (1) of the Act to carry out prescribed medical services (oral and maxillofacial surgery) contained in the Medicare Benefits Schedule book may perform prescribed medical services (oral and maxillofacial surgery) listed in Group C2 (on referral by an accredited orthodontist).

CB.1.6 The Medical Benefits (Dental Practitioners) Advisory Committee considers applications lodged by dental practitioners and recommends to the Minister the names of those dental practitioners who, in its opinion, should be approved by the Minister for the purposes of subsection 3(1) of the Act. Such dental practitioners must be State registered oral and maxillofacial surgeons in the State in which he/she is practising. In making its recommendations, the Committee may take into account a practitioner's training and experience in the field of oral and maxillofacial surgery and other factors which it may consider relevant.

CB.1.7 Practitioners who wish to be considered for approval or accreditation for the purposes of subsection 3(1) of the Act, should write to the

The Manager (Eligibility)
Medicare Australia
PO Box 1001
Tuggeranong ACT 2901

for an application form. Any enquiries may be directed to Medicare Australia on (02) 6124 6328.

CB.1.8 Where the Minister decides that a dental practitioner should not be accredited for orthodontic services, the dental practitioner may appeal to the Medical Benefits (Dental Practitioners) Appeals Committee, which is composed of dental practitioners who are not on the Advisory Committee. The Committee's address is the same as the Advisory Committee.

CB.1.9 Both the Advisory and the Appeals Committees are composed of dental practitioners nominated by the Australian Dental Association.

CC. PATIENT ELIGIBILITY

CC.1 Eligible Patients

CC.1.1 To be eligible to claim benefits for Schedule services performed by eligible dental practitioners, a patient must satisfy the following criteria:

- (a) The patient must be an Australian resident or any other person or class of persons whom the Minister declares to be eligible. All eligible persons will be issued with a Medicare card on application as evidence of their eligibility.
- (b) Under the provisions of Section 3BA of the Health Insurance Act a patient must be a prescribed dental patient, ie
 - a person aged up to twenty-two years, in respect of whom, a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*;
 - a person aged up to twenty-eight years, in respect of whom, prior to turning twenty-two years,
 - a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*, and
 - that person commenced treatment for a cleft lip or cleft palate condition;
 - a person aged twenty-eight and over requiring a specific course of treatment for the repair of previous reconstructive surgery, provided that:
 - prior to turning twenty-two years, a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*, and
 - the person received treatment for a cleft lip or cleft palate condition prior to turning twenty-eight years, and
 - if the Minister has declared in writing that he or she is satisfied that:
 - (i) because of exceptional circumstances, the person required repair of previous reconstructive surgery in connection with the condition, and
 - (ii) the person therefore needs to undergo that course of treatment.
 - a person aged up to twenty-two years in respect of whom a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a condition determined by the Minister to be a condition to which the definition of a prescribed dental patient under Section 3BA of the Act applies.

Conditions for which a patient may be prescribed include the following:

- AARSKOG
- Alagilles Syndrome
- Amelogenesis Imperfecta
- Anterior Open Bite
- Apert's Syndrome
- Branchial Arch Syndrome
- Charge Syndrome
- Choanal Atresia
- Cleidocranialdysostosis
- Craniometaphyseal Syndrome
- Craniosynostosis Syndrome
- Ectodermal Dysplasia
- Golden Har Syndrome
- Hypo Hidrotic Ectodermal Dysplasia
- Joubert Syndrome
- Left Hemifacial Microsomia
- Metopic Syndrome
- Oliogodontia
- Pierre Robin
- Pierre Sequence
- Regional Odontodysplasia

- Right Unicoronal Synostosis
- Romberg's Syndrome
- Rubenstein-Taybi Syndrome
- Sprintzen Syndrome
- Sticklers Syndrome
- Tessier Cleft
- Treacher-Collins' Syndrome
- Trichorhinophalangeal Syndrome Type 1
- Unilateral Cleft Lip and Palate (UCLP)
- Velocardio Facial Syndrome (VCF)

*Note: The above conditions have been listed in the terminology that they are generally known under. Some conditions are similar to, or otherwise known as, other conditions on the list.

Please contact Medicare Australia by telephone on 1300 652 492 if the condition is not listed here.

Applications for approval for repairs to previous reconstructive work

Applicants aged 28 and over seeking approval for repairs to previous reconstructive work under the Cleft Lip and Cleft Palate Scheme will be required to provide clinical details outlining the need for the repair of previous reconstructive surgery.

Patients aged over 28 years of age are not eligible to receive Medicare payments for treatment until approval from the Minister's delegate has been obtained.

Applications should include the following:

- a treatment plan devised by the treating professional, for the repair of the reconstructive surgery to be performed, including:
 - an indicative time period for which patient eligibility for claiming related treatments should be reinstated
 - date/s the treatment is expected to commence and
 - date/s the treatment is expected to be completed.
- proof of previous eligibility and treatment under the Cleft Lip and Cleft Palate Scheme. This should take the form of a letter from the treating practitioner, which lists the patient details as follows:
 - full name
 - date of birth
 - address
 - condition
 - Cleft Palate Number
 - date (or approximate) of original surgery

This information will be forwarded to Medicare Australia for confirmation of eligibility;

- a clinical report from the treating professional, describing the nature of the repair, information detailing the previous reconstructive surgery provided and an outline of the work to be undertaken.

Applications made under Section 3BA(2A) should be addressed to:

The Assistant Secretary
 (MBS Policy Implementation Branch)
 MDP 106
 Department of Health and Ageing
 PO Box 9848
 Canberra ACT 2601

Assessment of Applications

Assessment will take into account the information provided by the applicant and consider the circumstances surrounding each individual application. In the assessment, "previous reconstructive surgery" means surgery undertaken to repair structural defects in connection with a cleft lip or cleft palate condition. Repairs to this surgery must be in relation to the failure or deterioration of this surgery and due to that failure or deterioration, the patient requires further surgical intervention to restore optimal function.

Repair to previous reconstructive surgery may involve items in both the main Medicare Benefits Schedule, and items in the Cleft Lip and Cleft Palate Schedule. Under Section 3BA (2A), upon gaining the Minister's approval, applicants will have full access to items in the Cleft Lip and Cleft Palate Schedule that are necessary for the restoration of optimal function (provided the items are rendered by suitably qualified / approved practitioners).

CC.1.2 The identification of the cleft condition and the issue of the Certificate can be undertaken through a special cleft lip and cleft palate clinic or by a medical or dental practitioner authorised for this purpose by the Minister. Cleft lip and cleft palate clinics operate in at least one public hospital in each Australian State/Territory capital city. A list of these clinics and their addresses appears at the end of these Notes.

CC.1.3 Practitioners whose patients are unable to attend the hospital clinic should send records of the cleft condition to the Clinic for identification of the condition and issue of the Certificate.

CC.1.4 The Certificate is a formal document required under the provisions of the Act. Because the Certificate may have to last for up to twenty-eight years, each eligible patient will also be issued with a plastic identification card. These cards, which are more durable than the paper Certificates, can be used by patients (or parents or guardians) to claim Medicare benefits. Facsimiles of the Certificate and card appear at the end of these Notes.

CC.1.5 Patients are eligible for Medicare benefits for treatment received from the date of issue of their Certificate. Where treatment is required immediately after birth, practitioners should telephone a Clinic or approved practitioner so that a Certificate can be prepared which will be effective from that day.

CC.2 Visitors to Australia

CC.2.1 Medicare benefits are generally not payable to visitors to Australia or temporary residents.

CC.3 Health Care Expenses Incurred Overseas

CC.3.1 Medicare does not cover medical or hospital expenses incurred outside Australia.

CD. SCHEDULE FEES AND MEDICARE BENEFITS

CD.1 Schedule Fees and Medicare Benefits

CD.1.1 Medicare benefits are based on fees determined for each Schedule service. These fees are shown in the Schedule in Section 2 of this Book. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

CD.1.2 The 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 Medicare benefit payable exceed the fee actually charged.

There are presently two levels of Medicare benefit payable for cleft lip and cleft palate services:

- (a) **75% of the Schedule fee:**
- for professional services rendered to a privately insured patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' directly after an item number where used; or a description of the professional service, preceded by the word 'patient';
 - for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.
- (b) **85% of the Schedule fee**, or the Schedule fee less \$65.20 (indexed annually), whichever is the greater, for all other professional services.

CD.1.3 It should be noted that the Health Insurance Act makes provision for private medical insurance to cover the "patient gap" (ie, the difference between the Medicare benefit and the Schedule fee) for services attracting benefit at the 75% level. Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an agreement with their health fund.

CD.1.4 Where it can be established that payments for out-of-hospital services of \$335.50 (indexed annually from 1 January) have been made for a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee. This does not apply to the Assignment of Benefit arrangements. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

CD.1.5 Under the extended safety net, Medicare will meet 80% of the out-of-pocket costs (ie the difference between the fees charged by the doctor and the Medicare benefits paid) for out-of-hospital medical services, once an annual threshold of \$519.50 (indexed annually from 1 January) for families in receipt of the Family Tax Benefit Part A and concession card holders, or \$1,039.00 (indexed annually from 1 January) for all other individuals and families is reached. A family group

includes a spouse and dependent children under 16 years of age or dependent students under the age of 25. Individuals do not need to register with Medicare for the safety net threshold. However, families are required to register with Medicare to be eligible. Registration forms can be obtained from Medicare offices or completed online at www.health.gov.au or www.medicareaustralia.gov.au.

CD.2 Where Medicare Benefits are not Payable

CD.2.1 Medicare benefits are not payable in respect of a professional service where the medical expenses for the service:-

- (a) are paid/payable to a public hospital;
- (b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted);
- (c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;
- (d) are incurred in mass immunisation (see General Explanatory Note 12.3 for further explanation).

CD.2.2 Unless the Minister otherwise directs, Medicare benefits are not payable where:

- (a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;
- (b) the medical expenses are incurred by the employer of the person to whom the service is rendered;
- (c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or
- (d) the services is a health screening service.

CD.2.3 Benefits are not payable for items 75150 to 75621 unless the patient was referred in the manner outlined at paragraph CG.6.

CD.3 Limiting Rule

CD.3.1 In no circumstances will the benefit payable for a professional service exceed the fee charged for the service.

CE. PENALTIES

CE.1 Penalties

CE.1.1 Penalties of up to \$10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (oral or written) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court 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.

CE.1.2 A penalty of up to \$1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the obligatory details having been entered on the form before the person signs, or who fails to cause a patient to be given a copy of the completed form.

CF. BILLING PROCEDURES

CF.1 Billing of the Patient - Itemised Accounts

CF.1.1 Where the practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

CF.1.2 Under the provisions of the Health Insurance Act and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:-

- (a) Patient's name;
 - (b) The date on which the professional service was rendered;
 - (c) A description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital or day-hospital facility (other than a Medicare hospital patient), that is, the words (ie, accommodation and nursing care) "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;
 - (d) 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).
- CF.1.3 Each account must also carry a certification by the accredited dental practitioner that:-
- (a) the patient's eligibility certificate or identification card has been sighted (this can be done by quoting the number on the identification card); and
 - (b) the service was required for the treatment associated with the cleft condition.

CF.1.4 Where a practitioner wishes to apportion the total fee between the appropriate professional fee for the particular service and any balance outstanding in respect of services rendered previously, the practitioner should ensure that the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate service. In particular no item number should be shown against the balance.

CF.1.5 Only one original itemised account should be issued in respect of any one medical service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

CF.2 Claiming Benefits

CF.2.1 The patient, upon receipt of a practitioner's account, has three courses open for paying the account and receiving benefits as outlined below.

CF.3 Paid Accounts

CF.3.1 The patient may pay the account and subsequently present the receipt at a Medicare customer service centre for assessment and payment of the Medicare benefit in cash.

CF.3.2 In these circumstances, where a claimant personally attends a customer service centre, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

CF.3.3 In circumstances where the claimant is seeking a cheque payment of the Medicare benefit or is arranging for an agent to receive the Medicare benefit on the claimant's behalf, completion of a Medicare Patient Claim Form (PC1) is still required.

CF.4 Unpaid and Partially Paid Accounts

CF.4.1 Where the patient has not paid the account, the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the practitioner.

CF.4.2 It will be the patient's responsibility to forward the cheque to the practitioner and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits cannot be sent direct to practitioners or to patients at a practitioner's address (even if requested by the patient to do so). "Pay doctor" cheques will be forwarded to the claimant's last known address.

CF.4.3 When issuing a receipt to a patient in respect of an account that is being paid wholly or in part by a Medicare "pay doctor" cheque the practitioner should indicate on the receipt that a "Medicare" cheque for \$.....was involved in the payment of the account.

CF.5 Assignment of Benefits (Direct-Billing) Arrangements

CF.5.1 Under the Health Insurance Act the Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need. If a practitioner direct-bills, the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

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

CF.5.2 The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of **Medicare Australia**. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

CF.5.3 Under Medicare any eligible dental practitioner can accept assignment of benefit and direct-bill for any eligible person.

CF.6 Use of Medicare Cards in Direct Billing

CF.6.1 An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare card which shows the Medicare card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to 5 persons may be listed on the one Medicare card, and up to 9 persons may be listed under the one Medicare card number.

CF.6.2 The Medicare card plays an important part in direct billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter has been developed for this purpose and is available free of charge, on request, from Medicare.

CF.6.3 The patient details can of course be entered on the direct-bill forms by hand, but the use of a card to imprint patient details assists practitioners and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

CF.6.4 The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient is not eligible and Medicare benefits not payable.

CF.6.5 Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the practitioner may contact a Medicare telephone enquiry number to obtain the number.

CF.7 Assignment of Benefit Forms

CF.7.1 To meet varying requirements the following types of stationery are available from Medicare. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia.

- (a) *Form DB2*. This form is used to assign benefits for services other than requested pathology. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Patient copy and a Practitioner copy.
- (b) *Form DB4*. Is a continuous stationery version of Form DB2, and has been designed for use on most office accounting machines.

CF.8 The Claim for Assigned Benefits (Form DB1N, DB1H)

CF.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.

CF.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.

CF.9 Direct-Bill Stationery

CF.9.1 Medical practitioners and eligible dental practitioners wishing to direct-bill may obtain information on direct-bill stationery by telephoning **132150**. Information on the completion of the forms and direct-bill procedures are provided with the forms. Information on direct-billing is available from any Medicare office.

CF.10 Time Limits Applicable to Lodgement of Claims for Assigned Benefits

CF.10.1 A time limit of six months applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.

CF.10.2 Provision exists whereby in certain circumstances (eg hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

CG. COMPILATION AND INTERPRETATION OF THE SCHEDULE

CG.1 Compilation of the Schedule

CG.1.1 Section 2 of this Book lists the item number, description of medical service, the Schedule fee for those services in the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable and the Medicare benefits.

CG.1.2 The prescribed services have been grouped according to the general nature of the services: orthodontic, oral surgical and general and prosthodontic.

CG.2 Principles of Interpretation

CG.2.1 Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

CG.3 Multiple Operation Rule

CG.3.1 The Schedule fee for two or more operations performed on a patient on the one occasion is calculated by the following rule:-

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

NOTE:

1. Fees so calculated which result in a sum which is not a multiple of 5 cents are taken to the next higher multiple of 5 cents.
2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

CG.3.2 The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes items 75200- 75615.

CG.3.3 If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

CG.4 Administration of Anaesthetics by Medical Practitioners

CG.4.1 When a medical practitioner administers an anaesthetic in connection with a dental procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an eligible dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

CG.4.2 To ascertain the Schedule fee for the anaesthetic, medical practitioners should refer to Group T10 of the Medicare Benefits Schedule Book.

CG.5 Definitions

CG.5.1 Orthodontic treatment planning is defined as the measurement and analysis of the face and jaws and occlusion providing a diagnosis and planned prescription of appliances and treatment required.

CG.5.2 Study models are defined as orthodontic plaster casts of the upper and lower teeth and alveolar processes.

CG.6 Oral and Maxillofacial Surgical Services - Referral (75150 - 75621)

CG.6.1 Benefits are payable for items 75150 to 75621 only where the service has been rendered to a patient who has been referred by letter of Referral by a dental practitioner accredited for orthodontic services.

CG.7 General and Prosthodontic Services (75800)

CG.7.1 Item number 75800 refers to a consultation by a dentist for prevention and prophylaxis and includes such services as dietary advice, oral hygiene and fluoride treatment.

CG.8 Over-servicing

CG.8.1 Over-servicing must be avoided. In the case of denture services, examples of over-servicing might be:-

- Unjustifiably frequent replacement of dentures;
- Provision of new dentures when relining or re-modelling of an existing prosthesis would meet the clinical need;
- Provision of metal dentures where an acrylic denture would meet the clinical need.

CG.8.2 The Schedule includes an item for metal dentures to allow for the provision of a precise, long-term prosthesis. The item is not intended for use during the period of growth, where prostheses must be replaced or altered frequently, unless there is some definite and extraordinary clinical requirement.

ORTHODONTIC	ORTHODONTIC
GROUP C1 - ORTHODONTIC SERVICES	
<p><i>Note: In this Group, benefit is only payable where the service has been rendered to a patient by a dental practitioner who has been accredited by the Minister to provide orthodontic services, except for the services covered by Items 75009-75023 which may also be rendered by a dental practitioner approved by the Minister to provide oral surgical services.</i></p>	
CONSULTATIONS	
75001	INITIAL PROFESSIONAL ATTENDANCE in a single course of treatment by an accredited orthodontist Fee: \$77.25 Benefit: 75% = \$57.95 85% = \$65.70
75004	PROFESSIONAL ATTENDANCE by an accredited orthodontist subsequent to the first professional attendance by the orthodontist in a single course of treatment Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00
75006	PRODUCTION OF DENTAL STUDY MODELS (not being a service associated with a service to which item 75004 applies) prior to provision of a service to which: (a) item 75030, 75033, 75034, 75036, 75037, 75039, 75045 or 75051 applies; or (b) an item in Group T8 or Groups 03 to 09 applies; in a single course of treatment Fee: \$68.90 Benefit: 75% = \$51.70 85% = \$58.60
RADIOGRAPHY	
75009	ORTHODONTIC RADIOGRAPHY orthopantomography (panoramic radiography), including any consultation on the same occasion Fee: \$61.60 Benefit: 75% = \$46.20 85% = \$52.40
75012	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings OR LATERAL CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings including any consultation on the same occasion Fee: \$97.55 Benefit: 75% = \$73.20 85% = \$82.95
75015	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings including any consultation on the same occasion Fee: \$134.15 Benefit: 75% = \$100.65 85% = \$114.05
75018	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings and orthopantomography including any consultation on the same occasion Fee: \$170.90 Benefit: 75% = \$128.20 85% = \$145.30
75021	ORTHODONTIC RADIOGRAPHY hand-wrist studies (including growth prediction) including any consultation on the same occasion Fee: \$209.55 Benefit: 75% = \$157.20 85% = \$178.15
75023	INTRAORAL RADIOGRAPHY - single area, periapical or bitewing film Fee: \$41.95 Benefit: 75% = \$31.50 85% = \$35.70
PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING	
75024	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision - WHERE 1 APPLIANCE IS USED Fee: \$541.95 Benefit: 75% = \$406.50 85% = \$476.75
75027	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision WHERE 2 APPLIANCES ARE USED Fee: \$743.10 Benefit: 75% = \$557.35 85% = \$677.90
DENTITION TREATMENT	
75030	MAXILLARY ARCH EXPANSION not being a service associated with a service to which item 75039, 75042, 75045 or 75048 applies, including supply of appliances, all adjustments of the appliances, removal of the appliances and retention Fee: \$661.75 Benefit: 75% = \$496.35 85% = \$596.55

ORTHODONTIC		ORTHODONTIC
75033	MIXED DENTITION TREATMENT - incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of the appliances and retention Fee: \$1,084.55 Benefit: 75% = \$813.45 85% = \$1,019.35	
75034	MIXED DENTITION TREATMENT - incisor alignment with or without lateral arch expansion using a removable appliance in the maxillary arch, including supply of appliances, associated adjustments and retention Fee: \$552.00 Benefit: 75% = \$414.00 85% = \$486.80	
75036	MIXED DENTITION TREATMENT - lateral arch expansion and incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of appliances and retention Fee: \$1,498.00 Benefit: 75% = \$1,123.50 85% = \$1,432.80	
75037	MIXED DENTITION TREATMENT - lateral arch expansion and incisor correction - 2 arch (maxillary and mandibular) using fixed appliances in both maxillary and mandibular arches, including supply of appliances, all adjustments of appliances, removal of appliances and retention Fee: \$1,886.65 Benefit: 75% = \$1,415.00 85% = \$1,821.45	
75039	PERMANENT DENTITION TREATMENT SINGLE ARCH (mandibular or maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment Fee: \$501.40 Benefit: 75% = \$376.05 85% = \$436.20	
75042	PERMANENT DENTITION TREATMENT - SINGLE ARCH (mandibular or maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each 3 months of active treatment (including all adjustments and maintenance and removal of the appliances) after the first for a maximum of a further 33 months Fee: \$187.45 Benefit: 75% = \$140.60 85% = \$159.35	
75045	PERMANENT DENTITION TREATMENT 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment Fee: \$1,003.80 Benefit: 75% = \$752.85 85% = \$938.60	
75048	PERMANENT DENTITION TREATMENT - 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each subsequent 3 months of active treatment (including all adjustments and maintenance, and removal of the appliances) after the first for a maximum of a further 33 months Fee: \$257.45 Benefit: 75% = \$193.10 85% = \$218.85	
75049	RETENTION, FIXED OR REMOVABLE, single arch (mandibular or maxillary) - supply of retainer and supervision of retention Fee: \$301.25 Benefit: 75% = \$225.95 85% = \$256.10	
75050	RETENTION, FIXED OR REMOVABLE, 2-arch (mandibular and maxillary) - supply of retainers and supervision of retention Fee: \$581.60 Benefit: 75% = \$436.20 85% = \$516.40	
JAW GROWTH GUIDANCE		
75051	JAW GROWTH guidance using removable or functional appliances, including supply of appliances and all adjustments to appliances Fee: \$892.85 Benefit: 75% = \$669.65 85% = \$827.65	

GROUP C2 - ORAL AND MAXILLOFACIAL SERVICES

*Note: (i) In this Group, benefit is only payable where the service has been rendered to a patient who has been referred by an accredited orthodontist.
(ii) While benefit is payable for simple extractions performed by a registered dental practitioner, benefit is only payable for surgical extractions and other surgical procedures where the service is rendered by a dental practitioner who has been approved by the Minister to provide oral surgical services. (see para CBI.5)*

CONSULTATIONS

INITIAL PROFESSIONAL attendance in a single course of treatment by an accredited oral and maxillofacial surgeon where the patient is referred to the surgeon by an accredited orthodontist
(See para CG of explanatory notes to this Category)

75150 **Fee:** \$77.25 **Benefit:** 75% = \$57.95 85% = \$65.70

PROFESSIONAL ATTENDANCE by an accredited oral and maxillofacial surgeon subsequent to the first professional attendance by the surgeon in a single course of treatment where the patient is referred to the surgeon by an accredited orthodontist
(See para CG of explanatory notes to this Category)

75153 **Fee:** \$38.80 **Benefit:** 75% = \$29.10 85% = \$33.00

PRODUCTION OF DENTAL STUDY MODELS (not being a service associated with a service to which item 75153 applies) prior to provision of a service:
(a) to which item 52321, 53212 or 75618 applies; or
(b) to which an item in the series 52330 to 52382, 52600 to 52630, 53400 to 53409 or 53415 to 53429 applies;
in a single course of treatment
(See para CG of explanatory notes to this Category)

75156 **Fee:** \$68.90 **Benefit:** 75% = \$51.70 85% = \$58.60

SIMPLE EXTRACTIONS

REMOVAL OF TOOTH OR TOOTH FRAGMENT not being treatment to which item 75400, 75403, 75406, 75409, 75412 or 75415 applies
(See para CG of explanatory notes to this Category)

75200 **Fee:** \$49.60 **Benefit:** 75% = \$37.20 85% = \$42.20

REMOVAL OF TOOTH OR TOOTH FRAGMENT under general anaesthesia
(See para CG of explanatory notes to this Category)

75203 **Fee:** \$74.45 **Benefit:** 75% = \$55.85 85% = \$63.30

REMOVAL OF EACH ADDITIONAL TOOTH OR TOOTH FRAGMENT at the same attendance at which a service to which item 75200 or 75203 applies is rendered
(See para CG of explanatory notes to this Category)

75206 **Fee:** \$24.70 **Benefit:** 75% = \$18.55 85% = \$21.00

SURGICAL EXTRACTIONS

SURGICAL REMOVAL OF ERUPTED TOOTH
(See para CG of explanatory notes to this Category)

75400 **Fee:** \$148.85 **Benefit:** 75% = \$111.65 85% = \$126.55

SURGICAL REMOVAL OF TOOTH with soft tissue impaction
(See para CG of explanatory notes to this Category)

75403 **Fee:** \$170.90 **Benefit:** 75% = \$128.20 85% = \$145.30

SURGICAL REMOVAL OF TOOTH with partial bone impaction
(See para CG of explanatory notes to this Category)

75406 **Fee:** \$194.75 **Benefit:** 75% = \$146.10 85% = \$165.55

SURGICAL REMOVAL OF TOOTH with complete bone impaction
(See para CG of explanatory notes to this Category)

75409 **Fee:** \$220.60 **Benefit:** 75% = \$165.45 85% = \$187.55

SURGICAL REMOVAL OF TOOTH FRAGMENT involving soft tissue only
(See para CG of explanatory notes to this Category)

75412 **Fee:** \$123.20 **Benefit:** 75% = \$92.40 85% = \$104.75

ORAL AND MAXILLOFACIAL		ORAL AND MAXILLOFACIAL
75415	SURGICAL REMOVAL OF TOOTH FRAGMENT involving bone (See para CG of explanatory notes to this Category) Fee: \$148.85 Benefit: 75% = \$111.65 85% = \$126.55	
OTHER SURGICAL PROCEDURES		
75600	SURGICAL EXPOSURE, STIMULATION AND PACKING OF UNERUPTED TOOTH (See para CG of explanatory notes to this Category) Fee: \$209.55 Benefit: 75% = \$157.20 85% = \$178.15	
75603	SURGICAL EXPOSURE OF UNERUPTED TOOTH for the purpose of fitting a traction device (See para CG of explanatory notes to this Category) Fee: \$246.30 Benefit: 75% = \$184.75 85% = \$209.40	
75606	SURGICAL REPOSITIONING OF UNERUPTED TOOTH (See para CG of explanatory notes to this Category) Fee: \$246.30 Benefit: 75% = \$184.75 85% = \$209.40	
75609	TRANSPLANTATION OF TOOTH BUD (See para CG of explanatory notes to this Category) Fee: \$367.65 Benefit: 75% = \$275.75 85% = \$312.55	
75612	SURGICAL PROCEDURE for intra oral implantation of osseointegrated fixture (first stage) (See para CG of explanatory notes to this Category) Fee: \$455.05 Benefit: 75% = \$341.30 85% = \$389.85	
75615	SURGICAL PROCEDURE FOR FIXATION of trans-mucosal abutment (second stage of osseointegrated implant) (See para CG of explanatory notes to this Category) Fee: \$168.45 Benefit: 75% = \$126.35 85% = \$143.20	
75618	PROVISION AND FITTING OF A BITE RISING APPLIANCE or DENTAL SPLINT for the management of temporomandibular joint dysfunction syndrome (See para CG of explanatory notes to this Category) Fee: \$209.20 Benefit: 75% = \$156.90 85% = \$177.85	
75621	THE PROVISION AND FITTING OF SURGICAL TEMPLATE in conjunction with orthognathic surgical procedures in association with: (a) an item in the series 52342 to 52375; or (b) item 52380 or 52382 (See para CG of explanatory notes to this Category) Fee: \$209.20 Benefit: 75% = \$156.90 85% = \$177.85	

GENERAL AND PROSTHODONTIC**GENERAL AND PROSTHODONTIC**

75854	ADDITION OF A TOOTH OR TEETH to a partial denture to replace extracted tooth or teeth including taking of necessary impression Fee: \$110.25 Benefit: 75% = \$82.70 85% = \$93.75
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CATEGORY 8 - MISCELLANEOUS SERVICES INCLUDING ALLIED HEALTH AND DENTAL SERVICES

EXPLANATORY NOTES

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 Schedule Initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items 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 (refer M.7).

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.

In these notes, 'GP' means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

Services provided under the Psychological Therapy items will not attract a Medicare rebate unless:

- a referral has been made by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710);
- a referral has been made by a GP who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see M.6.3 for further details regarding psychiatrist and paediatrician referrals).

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: GP focussed psychological strategies services (items 2721 to 2727); and/or 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. Referrals should be provided, as required, in one or more groups of up to six sessions.

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above those already provided (to a maximum total of 18 individual services per patient per calendar year). Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group therapy services involving 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.

Service length and type

Services provided by eligible clinical psychologists under these items must be within the specified time period within the item descriptor. The clinical psychologist 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.

Course of treatment and reporting back to the referring medical practitioner

Patients are eligible to receive up to twelve individual services (up to eighteen in exceptional circumstances) and up to twelve group sessions in a calendar year.

Within this maximum service allocation, the clinical psychologist can provide one or more courses of treatment. For the purposes of the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). This enables the referring medical practitioner to consider a report from the clinical psychologist on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the clinical psychologist must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

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) individual services (apart from where exceptional circumstances apply) and twelve (12) group sessions 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

Items 80000 to 80020 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710), or under a referred psychiatrist assessment and management plan (item 291); 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 mental 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.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Medicare Australia will not be aware of the patient's eligibility. In this case the clinical psychologist should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

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. 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.

M.6.3 REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO CLINICAL PSYCHOLOGISTS FOR PSYCHOLOGICAL THERAPY)

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 a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 131.

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 for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity

Medicare benefits are available for up to twelve (12) individual (up to 18 services where exceptional circumstances apply) and/or twelve (12) group psychological therapy services and/or focussed psychological strategies services per patient per calendar year. Referrals should be made in one or more groups of up to six sessions. If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of twelve services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP, the GP may choose to use this visit to undertake a review of the patient's GP Mental Health Care Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Care Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Care Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

M.6.4 CLINICAL PSYCHOLOGIST PROFESSIONAL ELIGIBILITY

Eligible clinical psychologists

All consultations providing psychological therapy services must be rendered by a clinical psychologist who is a member of the Australian Psychological Society's College of Clinical Psychologists or meets the requirements for such membership, based on assessment by the Australian Psychological Society; 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.

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.

For providers, 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 Schedule Initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists (refer M.6); 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.

In these notes, ‘GP’ means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

Services provided under the focussed psychological strategies – allied mental health items will not attract a Medicare rebate unless:

- A referral has been made by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710);
- A referral has been made by a GP who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- A referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see M.7.3 for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates for up to twelve individual allied mental health services in a calendar year. These twelve services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or 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. Referrals should be provided, as required, in one or more groups of up to six sessions.

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above those already provided (to a maximum total of 18 services per patient per calendar year). Exceptional circumstances are defined as a significant change in the patient’s clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group therapy services involving 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.

After an initial group of up to six services, the allied mental health professional must provide a report to the referring practitioner. Following receipt of this report, the referring practitioner will consider the need for further treatment, before further allied mental health services may be provided.

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 mental 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 mental 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.

Course of treatment and reporting back to the referring medical practitioner

Patients are eligible to receive up to twelve individual services (up to eighteen in exceptional circumstances) and up to twelve group sessions in a calendar year.

Within this maximum service allocation, the allied mental health professional can provide one or more courses of treatment. For the purposes of the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the allied mental health professional must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

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 the maximum annual allowance of twelve (12) (apart from where exceptional circumstances apply) and twelve group sessions 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

Items 80100 to 80170 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710), or under a referred psychiatrist assessment and management plan (item 291); 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.

Allied Mental Health Professionals can call Medicare Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Medicare Australia will not be aware of the patient's eligibility. In this case the clinical psychologist should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

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. 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.

M.7.3 REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED MENTAL HEALTH PROFESSIONALS)

Referrals

Patients must be referred for focussed psychological strategies – allied mental health services by a GP managing the patient under a GP Mental Health Care Plan (item 2710), or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 131.

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 for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity

Medicare benefits are available for up to twelve (12) individual (up to 18 services where exceptional circumstances apply) and/or twelve (12) group psychological therapy services and/or focussed psychological strategies services per patient per calendar year. Referrals should be made in one or more groups of up to six sessions. If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of twelve services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP, the GP may choose to use this visit to undertake a review of the patient's GP Mental Health Care Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Care Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Care Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

M.7.4 ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

Allied mental 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 mental 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.

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

For providers, 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 ELIGIBLE PATIENTS

Medicare benefits are available 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. Services can be provided either by an eligible GP or by an eligible psychologist, social worker or mental health nurse on referral from a GP.

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).

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

M.8.2 ELIGIBLE 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.51.

Each individual allied health professional must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

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 that 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.

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.51). The Medicare benefit payable for an eligible service provided using item 81000, 81005 or 81010 is \$56.20.

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.

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.

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)

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 meet the following specific eligibility requirements, and are registered with Medicare Australia.

- 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 either as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999', (as in force on 1 November 2006) or as an Accredited Social Worker, 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 College of Mental Health Nurses, 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.

Further information

A copy of the Medicare Allied Health Supplement can be accessed from www.health.gov.au/mbsonline. 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.9 ALLIED HEALTH GROUP SERVICES (ITEMS 81100 TO 81125)

M.9.1 ELIGIBLE PATIENTS

MBS items (81100 to 81125) are available for allied health group services for patients with type 2 diabetes. These items apply to services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP.

Services available under these new items are in addition to the five individual allied health services available to patients each calendar year (refer to items 10950 to 10970 in explanatory note M.3).

To be eligible for these services, the patient must have in place one of the following:

- a GP Management Plan (GPMP) (item 721); or
- where a patient has an existing GP Management Plan, the GP has reviewed that plan (item 725); or
- for a resident of a residential aged care facility, the GP must have contributed to, or reviewed, a care plan prepared for them by the facility (item 731). [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, the resident may not need to be referred for allied health group services under these items, as the self management approach offered in group services may not be appropriate.]

Unlike the existing individual allied health services under items 10950 to 10970, there is no additional requirement for a Team Care Arrangement (item 723) in order for the patient to be referred for allied health group services.

Once the patient has been referred by their GP, a diabetes educator, exercise physiologist or dietitian will conduct an individual assessment (under items 81100, 81110 or 81120). A maximum of one (1) assessment service is available per calendar year. After assessment, the patient may receive up to eight (8) group services per calendar year from an eligible diabetes educator, exercise physiologist and/or dietitian (under items 81105, 81115 and 81125). A collaborative approach, where diabetes educators, exercise physiologists and dietitians work together to develop group service programs in their local area, is encouraged.

It is important to note that:

- before a Medicare rebate can be paid for the allied health assessment item (items 81100, 81110 or 81120) either the patient or the GP must have lodged a claim with Medicare Australia for the relevant GP care planning item and received payment for that claim; and
- before a Medicare rebate can be paid for the allied health group items (81105, 81115 and 81125) either the patient or the allied health professional must have lodged a claim with Medicare Australia for the assessment item and received payment for that claim.

M.9.2 GP REFERRAL REQUIREMENTS

The patient must be referred by their GP to an eligible allied health professional (diabetes educator, exercise physiologist or dietitian) who will undertake an individual assessment, preparing him/her for an appropriate group services program (under item 81100, 81110 or 81120).

When referring patients, GPs need to use the *Referral form for allied health group services under Medicare*, provided by the Commonwealth Department of Health and Ageing. The referral form can be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120. The form can be modified to suit practice needs (for example, relevant software packages) as long as the information is substantially retained.

GPs are also encouraged to provide a copy of the relevant part of the patient's care plan to the allied health professional.

M.9.3 ELIGIBLE ALLIED HEALTH PROFESSIONALS

Items 81100 to 81125 only apply to services provided by eligible diabetes educators, exercise physiologists and dietitians who are registered with Medicare Australia. If providers are already registered with Medicare Australia to use item 10951, 10953 or 10954, they do not need to register separately for items 81100 to 81125. Eligibility criteria are as follows:

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

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

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

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

M.9.4 ASSESSMENT FOR GROUP SERVICES (ITEMS 81100, 81110 AND 81120)

An assessment service is provided by a diabetes educator (item 81100), an exercise physiologist (item 81110) or a dietitian (item 81120), on referral from a GP.

The purpose of this service is to undertake an individual assessment of the patient and preparing him/her for an appropriate group services program. It involves taking a comprehensive patient history, identification of individual goals and preparing the patient for the group service. This may also provide an opportunity to identify any patient who is likely to be unsuitable for group services.

Number of services per year

Patients are eligible for a maximum of one assessment for group services (item 81100 **or** 81110 **or** 81120) per calendar year. If more than one assessment service is provided in a calendar year, the subsequent service/s will not attract a Medicare rebate and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for items 81100, 81110 or 81120, the allied health professional should contact Medicare Australia to confirm whether the appropriate care planning item is in place and/or the number of assessment services already claimed by the patient in the calendar year. Allied health professionals can call Medicare Australia on 132 011 to check this information.

Referral Form

The GP must refer the patient using the *Referral form for allied health group services under Medicare*. The allied health professional undertaking the assessment service will need to complete Part B of this form, and the patient will then need to present this form to the provider/s of group services.

Length of service

This service must be of at least 45 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

Rebate

The Medicare rebate for the assessment items is \$61.30.

Reporting Requirements

On completion of the assessment service, the allied health professional must provide a written report back to the referring GP outlining the assessment undertaken, whether the patient is suitable for group services and, if so, the nature of the group services to be delivered.

M.9.5 GROUP SERVICES (ITEMS 81105, 81115 AND 81125)

These services are provided in a group setting to assist with the management of type 2 diabetes.

Number of services per year

Patients are eligible for up to eight (8) allied health group services in total (81105, 81115 and 81125 inclusive) per calendar year. Each separate group service must be provided to the patient by only one type of allied health professional (i.e. either a diabetes educator, exercise physiologist or dietitian). However, the overall group services program provided for the patient could be comprised of one type of service only (eg 8 diabetes education services) or a combination of services (eg 3 diabetes education services, 3 dietitian services and 2 exercise physiology services). An eligible allied health professional with more than one Medicare provider number (eg for the provision of diabetes education and dietetics) may provide separate services under each of these provider numbers.

Allied health group service providers are strongly encouraged to deliver multidisciplinary group services programs that allow patients to benefit from a range of interventions designed to assist in the management of their type 2 diabetes.

Where a patient receives more than the limit of 8 group services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for group services, the allied health professional should contact Medicare Australia to confirm the number of group services already claimed by the patient in the calendar year. Allied health professionals can call Medicare Australia on 132 011 to check this information.

Multiple Services on the Same Day

Where clinically relevant, up to two group services may be provided consecutively on the same day by the same allied health professional.

Referral Form

The allied health professional/s undertaking the group services will need to receive the *Referral form for allied health group services under Medicare*, for which Part B has been completed by the provider who has undertaken the assessment service.

Group Size

The service must be provided to a person who is part of a group of between 2 and 12 persons.

Length of service

Each group service must be of at least 60 minutes duration.

Rebate

The Medicare rebate for items 81105, 81115 and 81125 is \$15.30 for each patient.

Reporting Requirements

On completion of the group services program, each allied health professional must provide, or contribute to, a written report back to the referring GP in respect of each patient. The report should describe the group services provided for the patient and indicate the outcomes achieved. While each allied health professional is required to provide feedback to the GP in relation to the group services that they provide to the patient, allied health professionals involved in the provision of a multidisciplinary program are encouraged to combine feedback into a single report to the referring GP.

M.9.6 ADDITIONAL REQUIREMENTS

Retention of Referral Form for Medicare Australia Audit Purposes

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

Publicly funded services

Items 81100 – 81125 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. 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 81100-81125 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 bulk billed.

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.

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.

M.9.7 FURTHER INFORMATION

Further information about these items is available on the Department of Health and Ageing’s website at www.health.gov.au/epc.

GROUP M6 - PSYCHOLOGICAL THERAPY SERVICES

	<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 or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>‡ + 80000 (Professional attendance at consulting rooms) (See para M.6 of explanatory notes to this Category) Fee: \$90.15 Benefit: 85% = \$76.65</p>
	<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) + 80005 Fee: \$112.60 Benefit: 85% = \$95.75</p>
	<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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>‡ + 80010 (Professional attendance at consulting rooms) (See para M.6 of explanatory notes to this Category) Fee: \$132.25 Benefit: 85% = \$112.45</p>
	<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) + 80015 Fee: \$154.75 Benefit: 85% = \$131.55</p>
	<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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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>‡ + 80020 - GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para M.6 of explanatory notes to this Category) Fee: \$33.60 Benefit: 85% = \$28.60</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; or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 Care Program 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.7 of explanatory notes to this Category) Fee: \$63.85 Benefit: 85% = \$54.30</p>
+ 80105	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the psychologist service requirements outlined for item 80100. (See para M.7 of explanatory notes to this Category) Fee: \$86.80 Benefit: 85% = \$73.80</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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 Care Program 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.7 of explanatory notes to this Category) Fee: \$90.15 Benefit: 85% = \$76.65</p>
+ 80115	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the psychologist service requirements outlined for item 80110. (See para M.7 of explanatory notes to this Category) Fee: \$113.15 Benefit: 85% = \$96.20</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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 (See para M.7 of explanatory notes to this Category) Fee: \$22.95 Benefit: 85% = \$19.55</p>

MISCELLANEOUS

MISCELLANEOUS

‡ + 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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional services at consulting rooms) (See para M.7 of explanatory notes to this Category) Fee: \$56.25 Benefit: 85% = \$47.85</p>
+ 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) Fee: \$79.20 Benefit: 85% = \$67.35</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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 Care Program 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.7 of explanatory notes to this Category) Fee: \$79.40 Benefit: 85% = \$67.50</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) Fee: \$102.35 Benefit: 85% = \$87.00</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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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) Fee: \$20.20 Benefit: 85% = \$17.20</p>

MISCELLANEOUS	MISCELLANEOUS
‡ + 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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 Care Program 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.7 of explanatory notes to this Category) Fee: \$56.25 Benefit: 85% = \$47.85</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) Fee: \$79.20 Benefit: 85% = \$67.35</p>
‡ + 80160	<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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 Care Program 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.7 of explanatory notes to this Category) Fee: \$79.40 Benefit: 85% = \$67.50</p>
+ 80165	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the social worker service requirements outlined for item 80160. (See para M.7 of explanatory notes to this Category) Fee: \$102.35 Benefit: 85% = \$87.00</p>
‡ + 80170	<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; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or 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 (See para M.7 of explanatory notes to this Category) Fee: \$20.20 Benefit: 85% = \$17.20</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. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.</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) Fee: \$66.10 Benefit: 85% = \$56.20</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. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.</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) Fee: \$66.10 Benefit: 85% = \$56.20</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. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.</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) Fee: \$66.10 Benefit: 85% = \$56.20</p>

GROUP M9 - ALLIED HEALTH GROUP SERVICES

DIABETES EDUCATION SERVICE – ASSESSMENT FOR GROUP SERVICES

Diabetes education health service provided to a person by an eligible diabetes educator for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

- (a) the service is provided to a person who has type 2 diabetes; and
- (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and
- (c) the person is referred to an 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
- (d) the person is not an admitted patient of a hospital; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 45 minutes duration; and
- (g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c); 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.

Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and 81120 apply).

(See para M.9 of explanatory notes to this Category)

+
†
81100

Fee: \$72.10 **Benefit:** 85% = \$61.30

DIABETES EDUCATION SERVICE – GROUP SERVICE

Diabetes education health service provided to a person by an eligible diabetes educator, as a GROUP SERVICE for the management of type 2 diabetes if:

- (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and
- (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and
- (c) the person is not an admitted patient of a hospital; and
- (d) the service is provided to a person involving the personal attendance by an eligible diabetes educator; and
- (e) the service is of at least 60 minutes duration; and
- (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible diabetes educator prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
- (g) an attendance record for the group is maintained by the eligible diabetes educator; 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 eight (8) GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

(See para M.9 of explanatory notes to this Category)

+
†
81105

Fee: \$18.00 **Benefit:** 85% = \$15.30

EXERCISE PHYSIOLOGY SERVICE – ASSESSMENT FOR GROUP SERVICES

Exercise physiology health service provided to a person by an eligible exercise physiologist for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

- (a) the service is provided to a person who has type 2 diabetes; and
- (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and
- (c) the person is referred to an 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; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 45 minutes duration; and
- (g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c); 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.

Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and 81120 apply).

(See para M.9 of explanatory notes to this Category)

+
†
81110

Fee: \$72.10 **Benefit:** 85% = \$61.30

EXERCISE PHYSIOLOGY SERVICE – GROUP SERVICE

Exercise physiology health service provided to a person by an eligible exercise physiologist, as a GROUP SERVICE for the management of type 2 diabetes if:

- (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 8100, 81110 or 81120; and
- (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and
- (c) the person is not an admitted patient of a hospital; and
- (d) the service is provided to a person involving the personal attendance by an eligible exercise physiologist; and
- (e) the service is of at least 60 minutes duration; and
- (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible exercise physiologist prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
- (g) an attendance record for the group is maintained by the eligible exercise physiologist; 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 eight (8) GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

(See para M.9 of explanatory notes to this Category)

+
†
81115

Fee: \$18.00 **Benefit:** 85% = \$15.30

GLOSSARY

Bulk billing	Where the patient assigns his/her Medicare benefit to the dental practitioner, who then seeks payment for the service from Medicare Australia. The dental practitioner accepts the Medicare benefit payable to the patient as full payment for the service and is not able (by law) to charge the patient a co-payment.
Chronic condition	A medical condition that has been or is likely to be present for at least six months including, <u>but not limited to</u> , asthma, cancer, cardiovascular illness, diabetes mellitus, arthritis, mental illness, musculoskeletal conditions and stroke. Relates to the GP Management Plan item (see below).
Complex care needs	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 other health or care providers. Relates to the Team Care Arrangements item (see below).
Dental practitioner	A generic reference to dentists, dental specialists and dental prosthetists used for the purposes of this book.
Dental specialist	Endodontist, Orthodontist, Oral and Maxillofacial Surgeon, Periodontist, Paedodontist (also known as Pedodontist and Pedodentist), Prosthodontist, Specialist in Oral Medicine and/or Oral Pathology, Dento-maxillofacial Radiologist, Oral Surgeon, or Special Needs Dentist.
DVA	Department of Veterans' Affairs
Extended Medicare Safety Net (EMSN)	Applies to all out-of-hospital services under Medicare, including medical, dental and allied health services. It is intended to protect patients and their families against high out-of-pocket costs on these services. For more information, see page 13.
General practitioner (GP)	A generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician).
GP Management Plan (GPMP)	Refers to Medicare item 721 (or review item 725). Involves a GP preparing a management plan for a patient with a chronic or terminal medical condition. Must be claimed with a TCA item (see below) before a patient can be referred by a GP for dental services.

MBS	Medicare Benefits Schedule
Medicare benefit/rebate	The amount paid by Medicare Australia to the patient (or the dental practitioner if bulk billed) for the service. The actual amount payable will sometimes vary from the benefit level printed in the Medicare Benefits Schedule, depending on whether the patient has reached their Extended Medicare Safety Net threshold and/or their limit of \$4,250 in dental benefits.
Medicare dental item	These are listed on pages 24-65. Includes the Medicare item number, descriptor, any limits, and the Medicare benefit for the service.
Out-of-pocket costs	The patient's financial contribution to the cost of the service, ie the difference between the amount charged by the dental practitioner and the Medicare benefit paid to the patient. Some out-of-pocket costs are covered by the Extended Medicare Safety Net.
Referral form	<i>Referral Form for Dental Services under Medicare</i> provided by the Department of Health and Ageing. For more information, see page 17.
Team Care Arrangements (TCA)	Refers to Medicare item 723 (or review item 727). Involves a GP coordinating multidisciplinary care for a patient with a chronic or terminal medical condition where the patient requires ongoing care from a team of at least two other health or care providers. Must be claimed with a GPMP item (see above) before a patient can be referred by a GP for dental services.

EXPLANATORY NOTE N.1: HOW TO USE THE MEDICARE DENTAL ITEMS

1. Overview

This book sets out the new Medicare arrangements for the provision of dental services to people with chronic medical conditions and complex care needs.

These arrangements commence on 1 November 2007 with the introduction of new Medicare dental items (85011 to 87777).

Eligible patients will be able to receive up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services over two consecutive calendar years.

To be eligible, a patient must meet certain eligibility criteria (described on page 9) and be referred by their GP to a dental practitioner.

The new Medicare items cover a comprehensive range of dental services provided by dentists, dental specialists and dental prosthetists. The Medicare items are based on the existing dental schedules used by the Department of Veterans' Affairs (DVA), with some modifications.

One of the key differences from the DVA dental arrangements is that, under Medicare, dental practitioners are free to set their own fees for services. Practitioners may choose to either bulk bill the patient, or charge above the Medicare rebate level. In the latter case, the patient will have an out-of-pocket cost that is not covered by Medicare.

Unlike the DVA arrangements, prior approval by a dental adviser is not required for any of the Medicare dental items. There are also no "fee-by-negotiation" items under Medicare. Instead, each Medicare item has a specific rebate amount.

There is a checklist to assist dental practitioners in using the Medicare dental items (see page 16).

The new dental items will replace the existing Enhanced Primary Care (EPC) dental items 10975 to 10977.

2. Which dental practitioners are eligible to use the dental items?

The dental items can be used by eligible dentists, dental specialists and dental prosthetists.

To be eligible, the dental practitioner must be:

- a recognised dentist, dental specialist or dental prosthetist who is registered or licensed under relevant state or territory law (with some limitations for dental prosthetists – see page 18); and
- registered with Medicare Australia (registration means having a Medicare provider/registration number for each practice location).

Dental practitioners may obtain the provider number/registration application form and the dental speciality registration form from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au.

Most dentists and dental specialists will already be registered with Medicare Australia prior to 1 November 2007 (eg to order diagnostic imaging or pathology tests under Medicare, or to use the existing EPC dental items).

Dentists

Where a dentist already has a Medicare provider/registration number, you will not need to re-register to use the new dental items.

Dental Specialists

The following dental specialists who are already registered with Medicare Australia and recognised by Medicare Australia in their relevant specialty, do not need to re-register to provide services under this initiative. They may use their current Medicare provider/registration number to provide services using items 86012-86986:

- Endodontists, Orthodontists, Periodontists, Paedodontists (also known as Pedodontists and Pedodontists), Prosthodontists, Specialists in Oral Medicine and/or Oral Pathology.

Some Oral and Maxillofacial Surgeons will need to re-register with Medicare Australia - see page 18.

From 1 November 2007 the following dental specialties will be recognised by Medicare Australia for the first time:

- Dento-maxillofacial radiology, Oral Surgery and Special Needs dentistry.

Practitioners in these specialties, who are already registered with Medicare Australia as a dentist, will need to register separately to provide services using the dental specialist items 86012-86986.

Dental Prosthetists

All dental prosthetists will need to apply for a provider/registration number with Medicare Australia to use the dental items. More information on eligibility for dental prosthetist registration is set out at page 18.

3. Which patients are eligible for dental services?

It is up to the GP to determine whether a patient is eligible for referral to a dental practitioner with reference to the following criteria.

Firstly, a person must:

- have a chronic medical condition and complex care needs (see below for more information); and
- their oral health must also be impacting on, or likely to impact on, their general health.

In practice, this means that the patient must have received the following GP care planning services in the last two years:

- a GP Management Plan (Medicare item 721 or 725); and
- Team Care Arrangements (Medicare item 723 or 727).

Residents of aged care facilities can also be referred for dental services under Medicare. For these patients, the GP must have contributed to or reviewed a multidisciplinary care plan prepared for the resident by the aged care facility (Medicare item 731) in the last two years.

Secondly, the patient's GP must refer the patient initially to a dentist or dental prosthetist. There is a referral form for the GP to use when referring a patient to a dental practitioner.

In most cases, the patient will be referred to a dentist in the first instance. In some limited cases, the GP may refer the patient directly to a dental prosthetist. This can be done where the patient has no natural teeth and requires dental prosthetic services only (eg full dentures) or requires repairs or maintenance for either full or partial dentures.

A dentist may subsequently refer a patient to another dentist, dental specialist or dental prosthetist. However, a patient cannot be referred directly to a dental specialist by a GP. For more information on the referral process refer to page 17.

Important – Medicare Australia cannot pay benefits for dental services until the required GP care planning items have been claimed and paid for the patient

It is strongly advised that, before providing any services to the patient, the dental practitioner (or receptionist) phones Medicare Australia on 132 150 to check that the relevant GP care planning items have been claimed and paid for the patient – even where the patient has a referral form signed by their GP.

If these care planning items have not been claimed and paid by Medicare Australia, no Medicare benefits for dental services can be paid to the patient. In this case, the dental practitioner should either refer the patient back to the GP, or after discussing the proposed charges with the patient, bill the patient privately (not covered by Medicare). The care plans cannot be done retrospectively, ie after the dental services have been provided to the patient.

Chronic medical conditions and complex care needs

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, arthritis, mental illness, musculoskeletal conditions, and stroke.

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 other health or care providers (eg an allied health professional or medical specialist). In some cases, the dental practitioner may be asked by the GP to be a member of the multidisciplinary team. A patient can still be referred for dental services under the Medicare items where the dental practitioner is not part of the patient's multidisciplinary team.

4. What dental services are covered by the Medicare items?

A comprehensive range of services is covered by the new dental items.

The items and Medicare rebate for each service are set out in three schedules (these can be found on pages 24-65):

- Services by eligible dentists (Medicare items 85011 - 85986)
- Services by eligible dental specialists (Medicare items 86012 - 86986)
- Services by eligible dental prosthetists (Medicare items 87011 - 87777).

Similar to the DVA items, the Medicare dental items are based on the Australian Dental Association (ADA) *Australian Schedule of Dental Services and Glossary, 8th Edition*. The Medicare dental items use an additional two digit prefix to distinguish between services by dentists, dental specialists and dental prosthetists. For example, Medicare item 85011 (used by dentists) corresponds to ADA item 011, Medicare item 86012 (used by dental specialists) corresponds to ADA item 012, and Medicare item 87071 (used by dental prosthetists) corresponds to ADA item 071.

Eligible dental specialists can use any of the dental specialist items 86012 – 86986. They are not limited to only using items related to their particular specialty.

For any service listed in the Medicare Benefit 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.

Clinically relevant services

The *Health Insurance Act 1973* requires that for a Medicare benefit to be payable, a professional service must be 'clinically relevant'. A clinically relevant service means a service which is provided by an eligible dentist, dental specialist or dental prosthetist and which is generally accepted by the dental profession as being necessary for the appropriate treatment of the patient.

Cosmetic services

The dental items can only be used where the primary objective of the treatment is to improve oral health and function. The items cannot be claimed for treatment that is predominantly for the improvement of the appearance of the patient (eg cosmetic). Services which aim to improve the health or function of the patient, but which also comprise a cosmetic component may be claimed.

Hospital services

The items can only be claimed for dental services provided in the community. Medicare benefits are not payable where the person requires dental services in a hospital as an admitted patient.

Limits on individual services

Some of the Medicare dental items have specific limitations or rules (eg frequency of the service, linkages between items, or other conditions on claiming). These limits and rules are set out in the individual item descriptors (see pages 24 to 65).

Dentures

There are some specific rules in relation to the provision of denture services (see page 20).

Publicly funded services

The Medicare dental items do not apply for services that are provided by any Commonwealth or State funded services.

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, the dental items can be claimed for services provided by eligible dentists, dental specialists or dental prosthetists salaried by, or contracted to, the Service or health clinic. All requirements of the relevant item must be met, including registration of the dental practitioner with Medicare Australia. These services must also be bulk billed.

5. How does the patient limit of \$4,250 in benefits work?

Eligible patients can access up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services over two consecutive calendar years. This limit applies to all dental services provided to the patient under items 85011-87777 by any eligible dentist, dental specialist or dental prosthetist.

More information on the operation of the Extended Medicare Safety Net is at page 13.

The two-year period is counted from the calendar year of the patient's first eligible dental service. For example, if the patient's first dental service is on 15 November 2007, the applicable two-year period will be the 2007 and 2008 calendar years. The next two-year period commences in the calendar year that the patient receives their next dental service.

Once a patient reaches their monetary limit of \$4,250, no further Medicare benefits are payable in that two calendar year period. This means that, where a patient receives a dental service that would otherwise take the patient over their limit, only the remaining balance (up to the \$4,250) will be paid for that service. This amount may be less than the standard Medicare rebate for that item. If this "final" claim is bulk billed, the dental practitioner will not be able to charge the patient a co-payment to make up the difference between the fee charged and the Medicare benefit payable.

Medicare Australia Enquiry Line

To help inform patients and dental practitioners about whether the patient will exceed their benefit limit of \$4,250 during the relevant two-year period, the patient (or dental practitioner) can call a Medicare Australia Enquiry Line to obtain a progressive total of dental benefits paid to the patient. Patients should call the Patient Enquiry Line on 132 011. Dental practitioners (or their receptionist) should call the Provider Enquiry Line on 132 150.

6. Informing the patient about the cost of services

To assist patients to understand the potential cost of dental services, dental practitioners will be required to provide patients with a written quote or cost estimate prior to commencing a course of treatment.

Therefore, following an examination and assessment of the patient (including any diagnostic tests), the dental practitioner must provide the patient with a proposed dental treatment plan including an itemised quotation of proposed charges for the future work.

7. Charging and billing for dental services

Deciding what to charge the patient

Like other providers under Medicare, dental practitioners are free to set their own fees for services. The dental practitioner may choose to either:

- bulk bill the patient (where the patient will not be charged a co-payment); or
- charge above the Medicare rebate (where the patient will have an out-of-pocket cost).

If the dental practitioner charges above the Medicare rebate for a service, the rules of the Extended Medicare Safety Net will apply up to the patient's limit of \$4,250.

Charges in excess of the \$4,250 are the sole responsibility of the patient. These charges will not attract a Medicare benefit and the Extended Medicare Safety Net arrangements will not apply.

Extended Medicare Safety Net

The Extended Medicare Safety Net applies to all out-of-hospital services under Medicare, including medical, dental and allied health services. It is intended to protect patients and their families against high out-of-pocket costs on these services.

The Extended Medicare Safety Net has two main elements:

- Firstly, any out-of-pocket costs incurred for eligible services will count towards the patient's (or the family's) annual Medicare Safety Net threshold (currently \$519.50 for concession cardholders and eligible families, and \$1,039.00 for all other individuals and families).
- Secondly, once a patient / family reaches their annual threshold, the Government will meet 80% of the out-of-pocket costs incurred for eligible services provided in the remainder of that calendar year.

These threshold amounts of \$519.50 and \$1,039.00 are indexed on 1 January each year.

An example of how the Extended Medicare Safety Net will work for dental services is set out below.

If a concessional patient (Mrs Jones) has already reached her annual Medicare Safety Net threshold of \$519.50 (on any out-of-hospital Medicare services), she will receive benefits as follows:

Service Provided	Dentist charge	MBS rebate	Safety Net benefit (80% x out-of-pocket cost) once threshold is reached	Total benefit paid to patient	Total out-of-pocket cost to patient
Examination	\$60	\$40	\$16	\$56	\$4
Extraction of tooth	\$180	\$100	\$64	\$164	\$16
TOTAL	\$240	\$140	\$80	\$220	\$20

Medicare Australia will automatically calculate the amount of the Medicare benefit payable to the patient.

How to seek payment for a service

Information on billing and claiming under Medicare is at pages 21-23.

8. Private health insurance

Patients with private health insurance covering dental services can decide to be treated under Medicare (ie not claim under their private health insurance), but patients cannot use their private health insurance ancillary cover to 'top up' the Medicare benefit they have received for a service.

9. Repeal of the existing EPC Medicare dental items 10975-10977

Eligible patients should access the new dental items from 1 November 2007.

The existing EPC dental items for people with chronic conditions and complex care needs (items 10975, 10976 and 10977) will remain in place until 31 December 2007 to enable patients to complete any treatment they have already commenced under these items (if they wish).

However, there is no requirement for existing patients to use all of their current entitlement of three dental services per calendar year before they can access the new dental items.

Existing patients can receive dental services under the new dental items from 1 November 2007, as long as they have a new referral from their GP.

For the period 1 November 2007 to 31 December 2007:

- Any Medicare benefits paid under the EPC dental items 10975-10977 will not count towards the patient's limit of \$4,250 over two consecutive calendar years for the new dental items 85011-87777.
- Any services provided under the new dental items 85011-87777 will not count towards the patient's limit of three dental services per calendar year under the EPC dental items 10975-10977.

As at 1 November 2007 (following indexation), the Medicare rebate for items 10975-10977 will be \$79.65.

The rules for items 10975-10977 are available on the Department's website at www.health.gov.au/mbsonline.

A comparison of the existing EPC dental items and the new Medicare dental items is at www.health.gov.au/epc.

10. More information and contacts

What	For Practitioners	For Patients	How
Medicare Australia provider enquiries, including: <ul style="list-style-type: none"> • General enquiries • Dental practitioner registration • Claiming (including forms) 	✓		132 150 Web: www.medicareaustralia.gov.au Direct Payment (Bulk Billing) forms: 1800 067 307
Medicare Australia patient enquiries		✓	132 011 Web: www.medicareaustralia.gov.au
GP Referral Forms	✓		Department of Health and Ageing Email: epc.items@health.gov.au Web: www.health.gov.au/epc Phone: 02 6289 4297 Facsimile: 02 6289 7120
Factsheets	✓	✓	
Standard Questions and Answers	✓	✓	
Medicare Benefits Schedule Dental Services Book	✓		
Schedule of Items*	✓		Pages 24-65 Web: www.health.gov.au/mbsonline

*Note: EPC dental items 10975, 10976 and 10977 may be viewed on MBS Online until 31 December 2007

Checklist for Dental Practitioners

MBS Items 85011- 85986 – used by Dentists
MBS Items 86012- 86986 – used by Dental Specialists
MBS Items 87011- 87777 – used by Dental Prosthetists

- Dental practitioner is registered with Medicare Australia (has a Medicare provider/registration number)
- Patient has been referred by a GP using an appropriate referral form.
- Dental practitioner/receptionist has called Medicare Australia on 132 150 to check:
 - that the required GP care planning items have been claimed and paid; and
 - how much of the \$4,250 in Medicare benefits available has already been claimed for the period.
- Referral form placed on patient's file.

Where the patient has been examined/assessed (including any diagnostic tests) and requires further work:

- Dental treatment plan including an itemised quotation of proposed charges provided to the patient.
- Copy or summary of treatment plan sent to referring GP (may be emailed).

Where the patient is bulk billed (Note: requirements may differ with electronic billing):

- Medicare approved bulk billing (assignment of benefit) form signed by patient and includes the information set out below under 'Billing details'.
- Completed claim forms sent to Medicare Australia.

Where the patient is billed directly – account is paid or unpaid:

- Itemised account/receipt given to the patient; includes the information set out below under 'Billing details'.

Billing details (Note: requirements may differ with electronic billing)

Bulk billing forms and patient's accounts and invoice must include the following information:

- Patient's name and date of service;
- MBS item numbers (and/or MBS service descriptions) - **using items relevant to profession**;
- Dental practitioners details - name and Medicare provider/registration number, or name and practice address;
- Referring GP details - name and Medicare provider/registration number, or name and practice address;
- Date of GP's referral; and
- For each bulk billed service, the amount of the Medicare rebate (ie which is being assigned by the patient to the practitioner); or;
For patient accounts, the amount charged, total amount paid, and any amount outstanding.

Where dental practitioner refers patient onto another dental practitioner:

- There is no prescribed form for referrals between dental practitioners, but a written note or letter of referral is required. A copy of the initial (GP) referral form must also be attached or sent with the referral note/letter to the receiving dental practitioner.
- The original or a copy of the GP referral form is placed on patient's file (by both the referring and receiving dental practitioner).

EXPLANATORY NOTE N.2: FURTHER INFORMATION

1. Referrals and reporting

Referral Form

Under these Medicare arrangements, a patient must first be referred by a GP to a dental practitioner. The GP must use the *Referral Form for Dental Services under Medicare* issued by the Department of Health and Ageing, or a form that substantially complies with this referral form. This new referral form will replace the Department's existing EPC referral form used for dental items 10975-10977.

The referral form may be given by the GP to the patient or sent directly to the dentist or dental prosthetist.

Dental practitioners are required to retain the original or a copy of the referral form (whichever is applicable) for 24 months from the date of the patient's first service (for Medicare Australia auditing purposes).

The referral form is not required to accompany Medicare claims (ie dental practitioners do not need to attach a signed copy of the form to patients' itemised accounts/receipts or the Medicare bulk billing forms).

New referrals

Where further dental services are required to treat a new or existing oral health problem at the end of a patient's current two-year benefits period, the patient will need to obtain a new referral from their GP. The patient's new two-year period will be counted from the calendar year of the patient's first eligible dental service under the new referral.

Communication with the referring GP

Dental practitioners must provide a copy or summary of the patient's treatment plan to the referring (medical) GP at the commencement of the course of treatment (ie following an examination and assessment of the patient, including any diagnostic tests).

The content of the treatment plan and/or feedback to the referring GP is a matter for the treating dental practitioner, having regard to the usual clinical reporting practices within the dental profession.

Referrals between dental practitioners

The dentist may provide services to the patient themselves and/or refer the patient onto another dentist, a dental specialist, or dental prosthetist.

The dental prosthetist may provide services to the patient themselves and/or refer the patient onto another dental prosthetist or dentist only (ie not a dental specialist).

In both cases, the referral may be a letter or note to an eligible dental practitioner signed and dated by the referring dentist or dental prosthetist.

There is no prescribed form for referrals between dental practitioners. However, a copy of the GP referral form must be attached to the dentist's/dental prosthetist's referral letter or note. This is because the dental practitioner receiving the referral from another dental practitioner will need to include the GP's details, including the date of the original referral from the GP, on their own account/receipt (see page 22).

2. Additional information on dental practitioner eligibility requirements and registration with Medicare Australia

Oral and Maxillofacial Surgeons

Oral and Maxillofacial surgeons will be able to use the dental specialist items 86012-86986 if they are registered with Medicare Australia as a dental specialist.

Medicare Australia recognised oral and maxillofacial surgeons with dental qualifications only, up to and including 31 October 2004. Since then, oral and maxillofacial surgeons have only been recognised by Medicare Australia where they also have a medical qualification and apply for recognition under the specialist recognition provisions of the *Health Insurance Act 1973* which apply to medical practitioners.

Therefore, oral and maxillofacial surgeons with dental qualifications only who are not currently recognised within their dental specialty by Medicare Australia (ie are recognised as a dentist only), will need to re-register with Medicare Australia to use the dental specialist items 86012-86986.

Registration with Medicare Australia to provide services under items 86012-86986 will not give Oral and Maxillofacial surgeons who do not meet the eligibility requirements of other Medicare items, the right to access those items (eg Category 4 items – Oral and maxillofacial services by approved dental practitioners).

Dental Prosthetists

Dental prosthetists are a new provider group under Medicare. Individual practitioners will need to apply for a provider/registration number with Medicare Australia before they can provide services under Medicare.

Dental prosthetists cannot use their existing DVA or private health insurance provider/registration number to claim under Medicare.

Registration with Medicare Australia will only allow dental prosthetists to claim services for eligible patients under the Medicare dental items 87011-87777. Dental prosthetists are currently not able to order diagnostic imaging tests under Medicare or access other Medicare items.

Eligibility for registration under Medicare (ie to apply for a provider number)

To be eligible to use the Medicare dental items 87011-87777, a dental prosthetist must be:

- an individual;
- registered or licensed to practice as a dental prosthetist under state or territory law (subject to the following limitations); and
- registered with Medicare Australia.

Where conditions or limits are imposed under relevant State or Territory law which prohibit a dental prosthetist from providing dental prosthetic services to patients, the dental prosthetist is not eligible to register with Medicare Australia to provide dental health services using items 87011-87777.

Students who are registered or licensed under relevant State or Territory law in order to complete a course of study or supervised training in dental prosthetics, are not eligible to register with Medicare Australia to provide dental health services using MBS items 87011-87777.

The following specific requirements also apply to dental prosthetists wishing to apply for a provider/registration number with Medicare Australia to use items 87011-87777.

‘Short-term’, interim’ or ‘provisional’ registration

Dental prosthetists whose registration or licence to practice is granted for a ‘short-term’, ‘interim’, or ‘provisional’ period only, will be registered by Medicare Australia to use items 87011-87777 for the stated period only. After this time, access to items 87011-87777 will only be continued where the practitioner provides Medicare Australia with evidence of their ongoing (ie current) registration or licence to practice as a dental prosthetist.

‘Company’ registration

Dental prosthetists whose registration or licence to practice is granted in the name of a ‘Company’ are not eligible to register with Medicare Australia to use items 87011-87777. In order to register with Medicare Australia to use items 87011-87777, the practitioner will need to provide Medicare Australia with evidence that they, as an individual, are registered or licensed to practice as a dental prosthetist under relevant state or territory law.

‘Non practising’ registration

Dental prosthetists whose registration or licence to practice is granted as ‘non-practising’ are not eligible to register with Medicare Australia to use items 87011-87777.

‘Limited’, ‘specific’ or ‘special purpose’ registration

Some dental prosthetists are prohibited from providing dental prosthetic services to patients where their registration or licence to practice is granted as ‘limited’, ‘specific’ or for a ‘special purpose’. Where a dental prosthetist is allowed by law to provide dental prosthetic services to patients under a ‘limited’, ‘specific’ or ‘special purpose’ registration or licence, the person will need to provide Medicare Australia with evidence that this is the case in order to be registered by Medicare Australia to use items 87011-87777. This may be in the form of advice from the relevant state or territory registration board.

3. Dentures

Changes from the EPC dental items

Under the EPC dental items (10975-10977), Medicare benefits are only payable for the fitting of dental prostheses. Costs associated with the making and supply of dental prostheses (eg laboratory costs for dentures) cannot be claimed under these items. Dental prosthetists are not eligible to register or provide services under Medicare.

The new Medicare dental items include a comprehensive range of services for dental prostheses, including dentures. Medicare benefits are now payable for the making, supply and fitting of dental prostheses. Services by dental prosthetists are covered under items 87011-87777. Dental prosthetists will need to apply for a provider/registration number with Medicare Australia to use these items – see page 18.

Limit of one set of new dentures every eight years

The intention is that patients should only receive Medicare benefits for a set of new dentures every eight years or more, with use of items for the maintenance or repair of dentures as clinically required.

In exceptional circumstances, a patient may receive a second set of new dentures during the eight-year period. Where a second set of new dentures is required, the new dentures may be provided by either the same practitioner or a different practitioner.

Exceptional circumstances refers to where there has been a significant change in the clinical condition of the patient which requires new dentures, or where a patient's existing dentures are irreparably damaged or lost.

Where exceptional circumstances apply, the patient's itemised receipt, account or Medicare bulk billing form must be annotated 'exceptional circumstances'. For audit purposes, the dental practitioner must also record in the patient's clinical notes the reason why the additional set of new dentures was required within the eight-year period.

For the purposes of the Medicare dental items, "set of new dentures" means either:

- complete maxillary and mandibular dentures (under items 85719, 86719 or 87719); OR
- a complete or partial maxillary denture (under items 85711, 86711, 87711, 85721, 86721, 87721, 85727, 86727 or 87727); and a complete or partial mandibular denture (under items 85712, 86712, 87712, 85722, 86722, 87722, 85728, 86728 or 87728).

4. Claiming under Medicare

Dental practitioners can bill patients for items 85011-87777 in three ways.

(i) **Bulk billing (also known as “direct payment” or an “assignment of benefit”) – manual claiming**

The dental practitioner can choose to bulk bill the patient (ie the patient assigns the Medicare benefit payable for the service to the dental practitioner). The dental practitioner accepts the relevant Medicare benefit as full payment for the service. By law, the dental practitioner cannot charge the patient a co-payment for a bulk billed service, irrespective of the purpose or title of the additional charge.

Medicare approved bulk billing (assignment of benefit) forms must be used for bulk billing. These are approved forms under the *Health Insurance Act 1973*, and no other documentation can be used to assign benefits without the approval of Medicare Australia. The approved forms can be obtained by either visiting the Medicare Australia website at www.medicareaustralia.gov.au or by telephoning 1800 067 307.

Bulk billing– electronic claiming

From 1 November 2007, dental practitioners will also be able to submit bulk billing claims (and patient claims) electronically via Medicare Easyclaim or Medicare Online – see below.

(ii) **Patient pays upfront (also known as a “patient claim”)**

The dental practitioner can require the patient to pay for the service in full at the end of a visit. The dental practitioner will need to provide the patient with an itemised account/receipt containing all of the details listed below.

It is then the patient’s responsibility to claim the relevant Medicare benefits from Medicare Australia (eg by visiting a Medicare office or sending a claim to Medicare Australia for payment by Electronic Funds Transfer (EFT)).

(iii) **Patient is given an invoice for an unpaid account**

The dental practitioner can provide the patient with an itemised account (invoice) containing all of the information listed below. In this case, the patient does not pay for the service at the time of the visit. Instead, the patient takes or sends the unpaid account to Medicare Australia for a Medicare benefits cheque to be issued in the dental practitioner’s name (for the total benefit payable to the patient for the service).

It is then the patient’s responsibility to provide the Medicare cheque to the dental practitioner and pay the balance of the account, if any.

When issuing a receipt to a patient for an amount that is being paid wholly or in part by a Medicare benefit cheque issued in the dental practitioner’s name, the dental practitioner should indicate on the receipt that a ‘Medicare cheque for \$... was included in the payment of the account’.

Information that must be included on a claim (for bulk billing, upfront payments, and unpaid accounts)

For a Medicare benefit to be paid for an eligible service, the following information must be included on the Medicare 'assignment of benefit' form (for bulk billed services), and the dental practitioner's itemised account/receipt (for upfront payment and unpaid accounts):

- patient's name;
- date of service;
- MBS item number(s) and/or MBS description of the service;
- dental practitioner's name and provider/registration number, or name and practice address;
- referring GP's name and provider/registration number, or name and practice address;
- date of GP referral; and
- the amount charged, that is:
 - for each bulk billed service, the amount of the Medicare rebate (ie which is being assigned by the patient to the practitioner); or
 - for patient accounts, the amount charged, total amount paid, and any amount outstanding in relation to the service.

Electronic claiming

From 1 November 2007, Medicare Australia will be able to accept Medicare claims lodged electronically by dental practitioners.

Electronic claiming removes the need for the practice to batch bulk bill claims at the end of the day. It also simplifies banking, with benefits paid into the practitioner's nominated bank account within 1-3 working days (instead of waiting up to 14 days for a cheque). Both of Medicare Australia's electronic claiming options, Medicare Online and Medicare Easyclaim, can process bulk bill and patient claims.

Medicare Online (previously called "HIC Online") is integrated with practice management software and lets practices lodge their claims and claim on behalf of their patients via the internet. Patients and practices can either receive their rebates directly into the nominated bank account within two to three days or by a cheque. Many software vendors have integrated Medicare Online into their products and a list is available on the Medicare Australia website under Health Care Providers /Online Initiative/Software Vendor lists.

Medicare Easyclaim uses existing EFTPOS technology and is currently available as a stand-alone system. An integrated option that 'talks to' practice management software is expected to be available in late 2007. Practices that lodge bulk bill claims through Medicare Easyclaim will receive their rebate (if getting paid by EFT) usually the next working day. For patient claims, the claimant will receive their rebate directly into their bank account almost immediately or via a cheque for payment to the provider.

For more information visit www.medicareaustralia.gov.au or call 1800 700 199.

Billing practices not permitted

Under the *Health Insurance Act 1973* (as amended), it is not permissible to:

- Include the cost of a non-clinically relevant service in a consultation charge. Medicare benefits can only be paid for clinically relevant services. If a dental practitioner chooses to use a procedure that is not generally accepted in their profession as necessary for the treatment of the patient, the cost of this procedure cannot be included in the fee for a Medicare item. Any charge for non-clinically relevant services must be separately listed on the account and not included in the fee billed to Medicare.
- Re-issue 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 dental practitioner must state the amount charged for the service provided and truly reflect what occurred between the patient and practitioner. While re-issuing an account to correct a genuine error is legitimate, 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.

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

Schedule of Dental Services

Services by

Eligible Dentists

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
GROUP N1 - SERVICES BY ELIGIBLE DENTISTS	
SUBGROUP 1 - DIAGNOSTIC SERVICES	
EXAMINATIONS	
† 85011	<p>Comprehensive oral examination Evaluation of all teeth, their supporting tissues and the oral tissues in order to record the condition of these structures. This evaluation includes recording an appropriate medical history and any other relevant information. Limit of one (1) per provider every 2 years. (See explanatory notes N.1 and N.2) Benefit: \$40.50</p>
† 85012	<p>Periodic oral examination An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic examination. Limit of one (1) per provider every 6 months. (See explanatory notes N.1 and N.2) Benefit: \$33.60</p>
† 85013	<p>Oral examination - limited A limited problem-focused oral evaluation carried out immediately prior to required treatment. This evaluation includes recording an appropriate medical history and any other relevant information. Limit of three (3) per 3 month period. (See explanatory notes N.1 and N.2) Benefit: \$21.15</p>
RADIOLOGICAL EXAMINATION AND INTERPRETATION	
† 85022	<p>Intraoral periapical or bitewing radiograph - per exposure Limit of six (6) per day. (See explanatory notes N.1 and N.2) Benefit: \$26.50</p>
† 85025	<p>Intraoral radiograph - occlusal, maxillary or mandibular - per exposure (See explanatory notes N.1 and N.2) Benefit: \$47.25</p>
† 85031	<p>Extraoral radiograph - maxillary, mandibular - per exposure (See explanatory notes N.1 and N.2) Benefit: \$53.85</p>
† 85037	<p>Panoramic radiograph - per exposure (See explanatory notes N.1 and N.2) Benefit: \$72.35</p>
† 85039	<p>Tomography of the skull or parts thereof Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$114.15</p>
OTHER DIAGNOSTIC SERVICES	
† 85047	<p>Caries activity screening test Limit one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$31.10</p>
† 85051	<p>Biopsy of tissue (See explanatory notes N.1 and N.2) Benefit: \$95.10</p>
† 85071	<p>Diagnostic model - per model (See explanatory notes N.1 and N.2) Benefit: \$46.40</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
SUBGROUP 2 - PREVENTIVE SERVICES	
DENTAL PROPHYLAXIS	
† 85111	Removal of plaque and/or stain. Limit of one (1) per 6 month period. (See explanatory notes N.1 and N.2) Benefit: \$41.35
† 85113	Recontouring pre-existing restoration(s) (See explanatory notes N.1 and N.2) Benefit: \$15.60
† 85114	Removal of calculus - first visit Limit of one (1) per 6 month period. (See explanatory notes N.1 and N.2) Benefit: \$68.85
† 85115	Removal of calculus - subsequent visit Limit of two (2) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$44.80
† 85117	Bleaching, internal - per tooth For non-vital discoloured tooth. (See explanatory notes N.1 and N.2) Benefit: \$161.35
REMINERALISING AGENTS	
† 85121	Topical application of remineralising agent - one treatment Limit of one (1) per 6 month period. (See explanatory notes N.1 and N.2) Benefit: \$26.55
† 85123	Concentrated remineralising agent, application - single tooth Limit of one (1) per day. (See explanatory notes N.1 and N.2) Benefit: \$20.80
OTHER PREVENTIVE SERVICES	
† 85131	Dietary advice Where a full appointment of at least 15 minutes is used. Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$28.00
† 85141	Oral hygiene instruction Where a full appointment of at least 15 minutes is used. Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$38.00
† 85161	Fissure sealing - per tooth (See explanatory notes N.1 and N.2) Benefit: \$35.35
† 85165	Desensitizing procedure - per visit (See explanatory notes N.1 and N.2) Benefit: \$20.80

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
† 85171	Odontoplasty - per tooth (See explanatory notes N.1 and N.2) Benefit: \$39.00
SUBGROUP 3 - PERIODONTICS	
† 85213	Treatment of acute periodontal infection - per visit Limit of two (2) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$53.50
† 85221	Clinical periodontal analysis and recording Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$40.65
† 85222	Root planing and subgingival curettage - per eight teeth or less Limit of two (2) per day. (See explanatory notes N.1 and N.2) Benefit: \$99.90
† 85225	Non-surgical periodontal treatment where not otherwise specified - per visit Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$81.15
† 85231	Gingivectomy - per eight teeth or less Limit of four (4) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$130.10
† 85232	Periodontal flap surgery - per eight teeth or less Limit of four (4) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$197.80
† 85233	Osseous surgery - per eight teeth or less Limit of four (4) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$333.30
† 85234	Osseous graft - per tooth or implant Limit of two (2) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$383.45
† 85238	Periodontal flap surgery for crown lengthening - per tooth (See explanatory notes N.1 and N.2) Benefit: \$184.05
† 85241	Root resection - per root (See explanatory notes N.1 and N.2) Benefit: \$153.35
† 85245	Periodontal surgery involving one tooth or an implant Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$60.95

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
SUBGROUP 4 - ORAL SURGERY	
EXTRACTIONS	
† 85311	<p>Removal of a tooth or part(s) thereof 1st tooth extracted. Inclusive of local anaesthesia and routine post-operative care. For additional extractions on the same day, use item 85316. Limit of one (1) per day. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$100.75</p>
† 85314	<p>Sectional removal of a tooth 1st sectional removal. Inclusive of local anaesthesia and routine post-operative care. For additional extractions on the same day, use item 85316. Limit of one (1) per day. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$128.80</p>
† 85316	<p>Additional extraction requiring removal of a tooth or part(s) thereof, or sectional removal of a tooth To be used for additional extractions on the same day in conjunction with items 85311 or 85314. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$74.80</p>
SURGICAL EXTRACTIONS	
† 85322	<p>Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division 1st tooth extracted. Inclusive of local anaesthesia and routine post-operative care. For additional surgical extractions on the same day, use item 85326. Limit of one (1) per day. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$163.55</p>
† 85323	<p>Surgical removal of a tooth or tooth fragment requiring removal of bone 1st tooth extracted. Inclusive of local anaesthesia and routine post-operative care. For additional surgical extractions on the same day, use item 85326. Limit of one (1) per day. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$186.80</p>
† 85324	<p>Surgical removal of a tooth or tooth fragment requiring both removal of bone and tooth division 1st tooth extracted. Inclusive of local anaesthesia and routine post-operative care. For additional surgical extractions on the same day, use item 85326. Limit of one (1) per day. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$251.35</p>
† 85326	<p>Additional extraction requiring surgical removal of a tooth or tooth fragment. To be used for additional surgical extractions on the same day in conjunction with items 85322, 85323 or 85324. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$157.55</p>
SURGERY FOR PROSTHESES	
† 85331	<p>Alveolectomy – per segment Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$102.00</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
† 85337	Reduction of fibrous tuberosity Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately (See explanatory notes N.1 and N.2) Benefit: \$143.35
† 85338	Reduction of flabby ridge – per segment Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately (See explanatory notes N.1 and N.2) Benefit: \$67.10
† 85341	Removal of hyperplastic tissue Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2) Benefit: \$155.40
GENERAL SURGICAL	
† 85377	Removal or repair of soft tissue (not elsewhere defined) Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$155.55
† 85378	Surgical removal of foreign body Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$88.05
OTHER SURGICAL PROCEDURES	
† 85381	Surgical exposure of unerupted tooth Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$220.45
† 85384	Repositioning of displaced tooth/teeth - per tooth Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$146.55
† 85386	Splinting of displaced tooth/teeth - per tooth Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$151.15
† 85387	Replantation and splinting of a tooth Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$296.00
† 85391	Frenectomy Includes insertion of sutures, normal post-operative care and suture removal (See explanatory notes N.1 and N.2) Benefit: \$135.80
† 85392	Incision and drainage of abscess or cyst Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$74.40

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
SUBGROUP 5 - ENDODONTICS	
PULP AND ROOT CANAL TREATMENTS	
† 85411	Direct pulp capping (See explanatory notes N.1 and N.2) Benefit: \$26.80
† 85412	Incomplete endodontic therapy (inoperable or fractured) (See explanatory notes N.1 and N.2) Benefit: \$91.60
† 85414	Pulpotomy (See explanatory notes N.1 and N.2) Benefit: \$58.40
† 85415	Complete chemo-mechanical preparation of root canal - one canal (See explanatory notes N.1 and N.2) Benefit: \$164.40
† 85416	Complete chemo-mechanical preparation of root canal - each additional canal on the same tooth. To be claimed in conjunction with item 85415. (See explanatory notes N.1 and N.2) Benefit: \$78.35
† 85417	Root canal obturation - one canal (See explanatory notes N.1 and N.2) Benefit: \$160.10
† 85418	Root canal obturation - each additional canal on the same tooth To be claimed in conjunction with item 85417. (See explanatory notes N.1 and N.2) Benefit: \$74.90
† 85419	Extirpation of pulp or debridement of root canal(s) - emergency or palliative (See explanatory notes N.1 and N.2) Benefit: \$105.90
PERIRADICULAR SURGERY	
† 85431	Periapical curettage - per root (See explanatory notes N.1 and N.2) Benefit: \$191.70
† 85432	Apicectomy - per root Includes curettage. (See explanatory notes N.1 and N.2) Benefit: \$238.00
† 85433	Exploratory periradicular surgery Limit of one (1) per 12 month period. Not claimable if services for the following items 85431, 85432, 85434, 85436, 85437 and 85438 are provided on the same day (See explanatory notes N.1 and N.2) Benefit: \$97.70
† 85434	Apical seal - per canal Includes apicectomy and periapical curettage. (See explanatory notes N.1 and N.2) Benefit: \$294.95
† 85436	Sealing of perforation (See explanatory notes N.1 and N.2) Benefit: \$182.10

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
† 85437	Surgical treatment and repair of an external root resorption - per tooth (See explanatory notes N.1 and N.2) Benefit: \$297.20
† 85438	Hemisection (See explanatory notes N.1 and N.2) Benefit: \$220.45
OTHER ENDODONTIC SERVICES	
† 85445	Exploration for a calcified root canal - per canal (See explanatory notes N.1 and N.2) Benefit: \$81.15
† 85451	Removal of root filling - per canal (See explanatory notes N.1 and N.2) Benefit: \$81.15
† 85452	Removal of cemented root canal post or post crown (See explanatory notes N.1 and N.2) Benefit: \$81.15
† 85453	Removal or bypassing fractured endodontic instrument (See explanatory notes N.1 and N.2) Benefit: \$67.70
† 85455	Additional visit for irrigation and/or dressing of the root canal system - per tooth Cannot be paid with items 85415, 85416, 85417 or 85418 on the same day. (See explanatory notes N.1 and N.2) Benefit: \$81.15
† 85457	Obturation of resorption defect or perforation (non-surgical) (See explanatory notes N.1 and N.2) Benefit: \$81.15
† 85458	Interim therapeutic root filling - per tooth Limit of three (3) in a 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$108.20
SUBGROUP 6 - RESTORATIVE SERVICES	
METALLIC RESTORATIONS - DIRECT	
† 85511	Metallic restoration - one surface - direct (See explanatory notes N.1 and N.2) Benefit: \$80.10
† 85512	Metallic restoration - two surfaces - direct (See explanatory notes N.1 and N.2) Benefit: \$98.15
† 85513	Metallic restoration - three surfaces - direct (See explanatory notes N.1 and N.2) Benefit: \$117.05
† 85514	Metallic restoration - four surfaces - direct (See explanatory notes N.1 and N.2) Benefit: \$133.45
† 85515	Metallic restoration - five surfaces - direct (See explanatory notes N.1 and N.2) Benefit: \$152.40

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
ADHESIVE RESTORATIONS - ANTERIOR TEETH - DIRECT	
† 85521	Adhesive restoration - one surface - anterior tooth - direct Limit of five (5) single-surface adhesive restorations (85521 or 85531) per day. (See explanatory notes N.1 and N.2) Benefit: \$88.70
† 85522	Adhesive restoration - two surfaces - anterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$107.60
† 85523	Adhesive restoration - three surfaces - anterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$127.40
† 85524	Adhesive restoration - four surfaces - anterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$147.20
† 85525	Adhesive restoration - five surfaces - anterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$173.05
ADHESIVE RESTORATIONS - POSTERIOR TEETH - DIRECT	
† 85531	Adhesive restoration - one surface - posterior tooth - direct Limit of five (5) single-surface adhesive restorations (85521 or 85531) per day. (See explanatory notes N.1 and N.2) Benefit: \$94.70
† 85532	Adhesive restoration - two surfaces - posterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$118.80
† 85533	Adhesive restoration - three surfaces - posterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$142.90
† 85534	Adhesive restoration - four surfaces - posterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$161.00
† 85535	Adhesive restoration - five surfaces - posterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$185.95
METALLIC RESTORATIONS - INDIRECT	
† 85541	Metallic restoration - one surface - indirect (See explanatory notes N.1 and N.2) Benefit: \$345.10
† 85542	Metallic restoration - two surfaces - indirect (See explanatory notes N.1 and N.2) Benefit: \$471.25
† 85543	Metallic restoration - three surfaces - indirect (See explanatory notes N.1 and N.2) Benefit: \$635.90
† 85544	Metallic restoration - four surfaces - indirect (See explanatory notes N.1 and N.2) Benefit: \$753.95
† 85545	Metallic restoration - five surfaces - indirect (See explanatory notes N.1 and N.2) Benefit: \$806.55

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
	TOOTH COLOURED RESTORATIONS - INDIRECT
† 85551	Tooth-coloured restoration - one surface - indirect (See explanatory notes N.1 and N.2) Benefit: \$431.70
† 85552	Tooth-coloured restoration - two surfaces - indirect (See explanatory notes N.1 and N.2) Benefit: \$613.75
† 85553	Tooth-coloured restoration - three surfaces - indirect (See explanatory notes N.1 and N.2) Benefit: \$719.80
† 85554	Tooth-coloured restoration - four surfaces - indirect (See explanatory notes N.1 and N.2) Benefit: \$822.80
† 85555	Tooth-coloured restoration - five surfaces - indirect (See explanatory notes N.1 and N.2) Benefit: \$784.20
	OTHER RESTORATIVE SERVICES
† 85572	Provisional (intermediate/ temporary) restoration Not claimable if services for endodontic items (85411 to 85458 inclusive) except 85419 are provided on the same day. Limit of three (3) per 3 month period. (See explanatory notes N.1 and N.2) Benefit: \$37.40
† 85574	Metal band The cementation of a metal band for diagnostic, protective purposes or for the placement of a provisional (intermediate) restoration. (See explanatory notes N.1 and N.2) Benefit: \$31.55
† 85575	Pin retention - per pin (See explanatory notes N.1 and N.2) Benefit: \$21.55
† 85576	Stainless steel crown (See explanatory notes N.1 and N.2) Benefit: \$163.00
† 85577	Cusp capping - per cusp (See explanatory notes N.1 and N.2) Benefit: \$23.25
† 85578	Restoration of an incisal corner - per corner (See explanatory notes N.1 and N.2) Benefit: \$23.25
† 85595	Removal of inlay/onlay (See explanatory notes N.1 and N.2) Benefit: \$74.40
† 85596	Recementing of inlay/onlay (See explanatory notes N.1 and N.2) Benefit: \$60.80
† 85597	Post - direct Insertion of a post into a prepared root canal to provide an anchor for an artificial crown or other restoration. (See explanatory notes N.1 and N.2) Benefit: \$113.25

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
SUBGROUP 7 - CROWN AND BRIDGE	
CROWNS	
† 85613	Full crown - non metallic - indirect (See explanatory notes N.1 and N.2) Benefit: \$1,031.15
† 85615	Full crown - veneered - indirect (See explanatory notes N.1 and N.2) Benefit: \$970.10
† 85618	Full crown - metallic - indirect (See explanatory notes N.1 and N.2) Benefit: \$909.00
† 85625	Core for crown including post - indirect (See explanatory notes N.1 and N.2) Benefit: \$245.40
† 85627	Preliminary restoration for crown - direct (See explanatory notes N.1 and N.2) Benefit: \$101.45
† 85629	Post and root cap - indirect (See explanatory notes N.1 and N.2) Benefit: \$257.05
TEMPORARY (PROVISIONAL) CROWN AND BRIDGE	
† 85631	Provisional crown (See explanatory notes N.1 and N.2) Benefit: \$117.00
† 85632	Provisional bridge - per pontic (See explanatory notes N.1 and N.2) Benefit: \$168.80
BRIDGES	
† 85642	Bridge pontic - direct - per pontic (See explanatory notes N.1 and N.2) Benefit: \$467.20
† 85643	Bridge pontic - indirect - per pontic (See explanatory notes N.1 and N.2) Benefit: \$745.05
† 85644	Semi-fixed attachment (See explanatory notes N.1 and N.2) Benefit: \$219.60
† 85645	Precision or magnetic attachment (See explanatory notes N.1 and N.2) Benefit: \$252.80
† 85649	Retainer for bonded fixture – indirect - per tooth (See explanatory notes N.1 and N.2) Benefit: \$245.65
CROWN AND BRIDGE REPAIRS AND OTHER SERVICES	
† 85651	Recementing crown or veneer (See explanatory notes N.1 and N.2) Benefit: \$79.20
† 85652	Recementing bridge or splint – per abutment (See explanatory notes N.1 and N.2) Benefit: \$77.30

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
† 85653	Rebonding of bridge or splint where retreatment of bridge surface is required (See explanatory notes N.1 and N.2) Benefit: \$70.35
† 85655	Removal of crown (See explanatory notes N.1 and N.2) Benefit: \$47.35
† 85656	Removal of bridge or splint (See explanatory notes N.1 and N.2) Benefit: \$142.00
† 85658	Repair of crown, bridge or splint – indirect. Inclusive of labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$293.30
† 85659	Repair of crown, bridge or splint – direct. (See explanatory notes N.1 and N.2) Benefit: \$193.35
IMPLANT PROSTHESES	
† 85661	Fitting of implant abutment – per abutment (See explanatory notes N.1 and N.2) Benefit: \$454.90
† 85669	Removal and reattachment of prosthesis fixed to implant(s) – per implant (See explanatory notes N.1 and N.2) Benefit: \$124.65
† 85671	Full crown attached to osseointegrated implant – non metallic – indirect (See explanatory notes N.1 and N.2) Benefit: \$1,031.15
† 85672	Full crown attached to osseointegrated implant – veneered – indirect (See explanatory notes N.1 and N.2) Benefit: \$1,168.10
† 85673	Full crown attached to osseointegrated implant – metallic – indirect (See explanatory notes N.1 and N.2) Benefit: \$910.25
SUBGROUP 8 - PROSTHODONTICS	
DENTURES AND DENTURE COMPONENTS	
† 85711	Complete maxillary denture Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20) Benefit: \$732.50
† 85712	Complete mandibular denture Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20) Benefit: \$732.50
† 85716	Metal palate or plate Additional to items 85711, 85712 or 85719. (See explanatory notes N.1 and N.2) Benefit: \$242.45

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
† 85719	<p>Complete maxillary and mandibular dentures</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20)</p> <p>Benefit: \$1,298.90</p>
† 85721	<p>Partial maxillary denture - resin base</p> <p>Base amount only. To be claimed in conjunction with item 85733 for each additional tooth.</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period (See explanatory notes N.1 and N.2, in particular page 20)</p> <p>Benefit: \$326.25</p>
† 85722	<p>Partial mandibular denture - resin base</p> <p>Base amount only. To be claimed in conjunction with item 85733 for each additional tooth.</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20)</p> <p>Benefit: \$326.25</p>
† 85727	<p>Partial maxillary denture - cast metal framework (includes provision of casting)</p> <p>Inclusive of clasps, retainers and occlusal rests.</p> <p>Base amount only. To be claimed in conjunction with item 85733 for each additional tooth and item 85739 for each metal backing.</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20)</p> <p>Benefit: \$1,080.70</p>
† 85728	<p>Partial mandibular denture - cast metal framework (includes provision of casting)</p> <p>Inclusive of clasps, retainers and occlusal rests.</p> <p>Base amount only. To be claimed in conjunction with item 85733 for each additional tooth and item 85739 for each metal backing.</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20)</p> <p>Benefit: \$1,080.70</p>
† 85731	<p>Retainer - per tooth</p> <p>Additional to items 85721 and 85722. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$33.85</p>
† 85732	<p>Occlusal rest - per rest</p> <p>Additional to items 85721 and 85722. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$16.45</p>
† 85733	<p>Tooth/Teeth (Partial denture)</p> <p>An item to describe each tooth added to the base of new partial denture. The number of teeth should be indicated. To be claimed with items 85721, 85722, 85727 or 85728.</p> <p>Limit of twelve (12) per base. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$34.95</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
† 85735	Precision or magnetic attachment (See explanatory notes N.1 and N.2) Benefit: \$195.65
† 85736	Immediate tooth replacement - per tooth (See explanatory notes N.1 and N.2) Benefit: \$7.00
† 85737	Resilient lining (See explanatory notes N.1 and N.2) Benefit: \$145.20
† 85738	Wrought bar A wrought bar joining sections of a partial prosthesis. (See explanatory notes N.1 and N.2) Benefit: \$135.30
† 85739	Metal Backing – per backing An extension of the casting of a cast metal partial denture to provide a backing for the denture tooth. The number of backings should be indicated. To be claimed with items 85727 or 85728. (See explanatory notes N.1 and N.2) Benefit: \$61.15
DENTURE MAINTENANCE	
† 85741	Adjustment of a denture Adjustment of a denture to improve comfort and function. This item cannot be claimed for routine adjustments following the insertion of a new denture or maintenance or repair of an existing denture. (See explanatory notes N.1 and N.2) Benefit: \$40.10
† 85743	Relining - complete denture - processed For soft relines, use items 85743 and 85737. (See explanatory notes N.1 and N.2) Benefit: \$255.70
† 85744	Relining - partial denture - processed For soft relines, use items 85744 and 85737. (See explanatory notes N.1 and N.2) Benefit: \$217.90
† 85745	Remodelling - complete denture (See explanatory notes N.1 and N.2) Benefit: \$407.45
† 85746	Remodelling - partial denture (See explanatory notes N.1 and N.2) Benefit: \$343.50
† 85751	Relining - complete denture - direct Chair-side only. Either hard or soft material. (See explanatory notes N.1 and N.2) Benefit: \$139.85
† 85752	Relining - partial denture - direct (See explanatory notes N.1 and N.2) Benefit: \$117.90
† 85753	Cleaning and polishing of pre-existing denture Limit of one (1) per 2 year period. (See explanatory notes N.1 and N.2) Benefit: \$32.55

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
DENTURE REPAIRS	
† 85761	Reattaching pre-existing tooth or clasp to denture. Inclusive of labour and laboratory costs (See explanatory notes N.1 and N.2) Benefit: \$110.70
† 85762	Replacing clasp on denture (See explanatory notes N.1 and N.2) Benefit: \$115.65
† 85763	Repairing broken base of a complete denture. Inclusive of labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$99.90
† 85764	Repairing broken base of a partial denture. Inclusive of labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$110.70
† 85765	Replacing first tooth on denture (See explanatory notes N.1 and N.2) Benefit: \$115.65
† 85767	Any repair or tooth replacement in addition to other repairs, alterations or other modifications for same denture on same day. Inclusive of labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$45.75
† 85768	Adding tooth to partial denture to replace an extracted or decoronated tooth - per tooth (See explanatory notes N.1 and N.2) Benefit: \$117.05
† 85769	Repair or addition to metal casting (See explanatory notes N.1 and N.2) Benefit: \$140.00
OTHER PROSTHODONTIC SERVICES	
† 85771	Tissue conditioning treatment prior to impressions Limit of five (5) per 3 month period. (See explanatory notes N.1 and N.2) Benefit: \$53.15
† 85772	Splint - resin - indirect (See explanatory notes N.1 and N.2) Benefit: \$208.05
† 85773	Splint - metal - indirect (See explanatory notes N.1 and N.2) Benefit: \$220.45
† 85776	Impression where required for denture repair/modification (See explanatory notes N.1 and N.2) Benefit: \$35.35
† 85777	Identification Marking a dental appliance with a patient's name or other form of enduring patient identification. (See explanatory notes N.1 and N.2) Benefit: \$28.30

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
	SUBGROUP 9 - ORTHODONTICS
	REMOVABLE APPLIANCES
† 85811	Passive removable appliance - per arch (See explanatory notes N.1 and N.2) Benefit: \$249.25
† 85821	Active removable appliance - per arch (See explanatory notes N.1 and N.2) Benefit: \$438.65
† 85823	Functional orthopaedic appliance (See explanatory notes N.1 and N.2) Benefit: \$373.85
	FIXED APPLIANCES
† 85829	Partial banding - per arch (See explanatory notes N.1 and N.2) Benefit: \$460.10
† 85831	Full arch banding - per arch (See explanatory notes N.1 and N.2) Benefit: \$1,264.70
	SUBGROUP 10 - GENERAL SERVICES
	EMERGENCIES
† 85911	Palliative care Interim care to relieve pain, infection, bleeding or other problems not associated with other treatment. (See explanatory notes N.1 and N.2) Benefit: \$52.55
	DRUG THERAPY
† 85926	Individually made tray – medicaments A tray made for the application of medicaments to the teeth or supporting tissues. Not to be claimed for bleaching. (See explanatory notes N.1 and N.2) Benefit: \$121.75
† 85927	Provision of medication/ medicament The supply, prescription or administration of appropriate medications and medicaments required for dental treatment. Limit of one (1) per three month period. (See explanatory notes N.1 and N.2) Benefit: \$21.15
	ANAESTHESIA AND SEDATION
† 85949	Treatment under general anaesthesia A specialist anaesthetist must administer the anaesthetic. (See explanatory notes N.1 and N.2) Benefit: \$127.70
	OCCLUSAL THERAPY
† 85963	Clinical occlusal analysis including muscle and joint palpation Limit of one (1) per three year period. (See explanatory notes N.1 and N.2) Benefit: \$67.70

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTISTS	
† 85964	Registration and mounting of casts for occlusal analysis Limit of one (1) per three year period. (See explanatory notes N.1 and N.2) Benefit: \$58.00
† 85965	Occlusal splint (See explanatory notes N.1 and N.2) Benefit: \$408.95
† 85966	Adjustment of pre-existing occlusal splint - per visit (See explanatory notes N.1 and N.2) Benefit: \$56.70
† 85968	Occlusal adjustment following occlusal analysis - per visit (See explanatory notes N.1 and N.2) Benefit: \$82.35
† 85971	Adjunctive physical therapy for temporomandibular joint and associated structures Limit of four (4) per 12 month period (See explanatory notes N.1 and N.2) Benefit: \$47.95
† 85972	Repair/addition - occlusal splint (See explanatory notes N.1 and N.2) Benefit: \$169.35
MISCELLANEOUS	
† 85981	Splinting and stabilisation - direct - per tooth (See explanatory notes N.1 and N.2) Benefit: \$74.40
† 85986	Post-operative care where not otherwise included In normal circumstances, dentists provide post-operative care following dental treatment. However, where a patient requires unforeseen post-operative care or is seen by a dentist who did not provide the initial treatment, this item can be used. Limit of two (2) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$54.15

Schedule of Dental Services

Services by

Eligible Dental Specialists

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
GROUP N2 - SERVICES BY ELIGIBLE DENTAL SPECIALISTS	
SUBGROUP 1 - DIAGNOSTIC SERVICES	
EXAMINATIONS	
† 86012	<p>Periodic oral examination An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous periodic examination. Limit of one (1) per provider every 6 months. (See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$33.60</p>
† 86013	<p>Oral examination - limited A limited problem-focused oral evaluation carried out immediately prior to required treatment. This evaluation includes recording an appropriate medical history and any other relevant information. Limit of three (3) per 3 month period. (See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$21.15</p>
† 86014	<p>Consultation A consultation to seek advice or discuss treatment options regarding a specific dental or oral condition. This consultation includes recording an appropriate medical history and any other relevant information. (See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$48.75</p>
† 86015	<p>Consultation - extended (30 mins) An extended consultation to seek advice or discuss treatment options regarding a specific dental or oral complaint. This consultation includes recording an appropriate medical history and any other relevant information. Limit of one (1) per provider per 12 month period. (See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$79.75</p>
RADIOLOGICAL EXAMINATION AND INTERPRETATION	
† 86022	<p>Intraoral periapical or bitewing radiograph - per exposure Limit of six (6) per day. (See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$26.50</p>
† 86025	<p>Intraoral radiograph - occlusal, maxillary or mandibular - per exposure (See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$47.25</p>
† 86031	<p>Extraoral radiograph - maxillary, mandibular - per exposure (See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$53.85</p>
† 86035	<p>Radiograph of temporomandibular joint - per exposure (See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$77.65</p>
† 86036	<p>Cephalometric radiograph - lateral, antero-posterior, postero-anterior or submento-vertex – per exposure Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$114.05</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86037	Panoramic radiograph - per exposure (See explanatory notes N.1 and N.2) Benefit: \$72.35
† 86038	Hand-wrist radiograph for skeletal age assessment Limit of one (1) per provider per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$67.70
† 86039	Tomography of the skull or parts thereof Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$114.15
OTHER DIAGNOSTIC SERVICES	
† 86047	Caries activity screening test Limit one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$31.10
† 86051	Biopsy of tissue (See explanatory notes N.1 and N.2) Benefit: \$95.10
† 86071	Diagnostic model - per model (See explanatory notes N.1 and N.2) Benefit: \$46.40
† 86082	Tooth-jaw size prediction analysis Limit of one (1) per provider per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$81.15
SUBGROUP 2 - PREVENTIVE SERVICES	
DENTAL PROPHYLAXIS	
† 86111	Removal of plaque and/or stain Limit of one (1) per 6 month period. (See explanatory notes N.1 and N.2) Benefit: \$41.35
† 86113	Recontouring pre-existing restoration(s) (See explanatory notes N.1 and N.2) Benefit: \$15.60
† 86114	Removal of calculus - first visit Limit of one (1) per 6 month period. (See explanatory notes N.1 and N.2) Benefit: \$68.85
† 86115	Removal of calculus - subsequent visit Limit of two (2) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$44.80
† 86117	Bleaching, internal - per tooth For non-vital discoloured tooth. (See explanatory notes N.1 and N.2) Benefit: \$217.85

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
	REMINERALISING AGENTS
† 86121	Topical application of remineralising agent - one treatment Limit of one (1) per 6 month period. (See explanatory notes N.1 and N.2) Benefit: \$26.55
† 86123	Concentrated remineralising agent, application - single tooth Limit of one (1) per day. (See explanatory notes N.1 and N.2) Benefit: \$20.80
	OTHER PREVENTIVE SERVICES
† 86131	Dietary advice Where a full appointment of at least 15 minutes is used. Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$28.00
† 86141	Oral hygiene instruction Where a full appointment of at least 15 minutes is used. Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$38.00
† 86161	Fissure sealing - per tooth (See explanatory notes N.1 and N.2) Benefit: \$35.35
† 86165	Desensitizing procedure - per visit (See explanatory notes N.1 and N.2) Benefit: \$20.80
† 86171	Odontoplasty - per tooth (See explanatory notes N.1 and N.2) Benefit: \$39.00
	SUBGROUP 3 - PERIODONTICS
† 86213	Treatment of acute periodontal infection - per visit Limit of two (2) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$53.50
† 86221	Clinical periodontal analysis and recording Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$108.20
† 86222	Root planning and subgingival curettage - per eight teeth or less Limit of two (2) per day. (See explanatory notes N.1 and N.2) Benefit: \$138.05
† 86225	Non-surgical periodontal treatment where not otherwise specified - per visit Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$108.20

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86231	Gingivectomy - per eight teeth or less Limit of four (4) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$182.10
† 86232	Periodontal flap surgery - per eight teeth or less Limit of four (4) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$301.70
† 86233	Osseous surgery - per eight teeth or less Limit of four (4) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$449.95
† 86234	Osseous graft - per tooth or implant Limit of two (2) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$498.45
† 86235	Gingival graft - per tooth or implant Limit of two (2) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$335.50
† 86236	Guided tissue regeneration - per tooth or implant (See explanatory notes N.1 and N.2) Benefit: \$401.50
† 86237	Guided tissue regeneration - membrane removal (See explanatory notes N.1 and N.2) Benefit: \$172.55
† 86238	Periodontal flap surgery for crown lengthening - per tooth (See explanatory notes N.1 and N.2) Benefit: \$310.25
† 86241	Root resection - per root (See explanatory notes N.1 and N.2) Benefit: \$191.70
† 86245	Periodontal surgery involving one tooth or an implant Limit of one (1) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$121.75
SUBGROUP 4 - ORAL SURGERY	
EXTRACTIONS	
† 86311	Removal of a tooth or part(s) thereof 1 st tooth extracted. Inclusive of local anaesthesia and routine post-operative care. For additional extractions on the same day, use item 86316. Limit of one (1) per day. (See explanatory notes N.1 and N.2) Benefit: \$125.25

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86314	<p>Sectional removal of a tooth 1st sectional removal. Inclusive of local anaesthesia and routine post-operative care. For additional extractions on the same day, use item 86316. Limit of one (1) per day. (See explanatory notes N.1 and N.2) Benefit: \$171.40</p>
† 86316	<p>Additional extraction requiring removal of a tooth or part(s) thereof, or sectional removal of a tooth To be used for additional extractions on the same day in conjunction with items 86311 or 86314. (See explanatory notes N.1 and N.2) Benefit: \$95.40</p>
SURGICAL EXTRACTIONS	
† 86322	<p>Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division 1st tooth extracted. Inclusive of local anaesthesia and routine post-operative care. For additional surgical extractions on the same day, use item 86326. Limit of one (1) per day. (See explanatory notes N.1 and N.2) Benefit: \$217.50</p>
† 86323	<p>Surgical removal of a tooth or tooth fragment requiring removal of bone 1st tooth extracted. Inclusive of local anaesthesia and routine post-operative care. For additional surgical extractions on the same day, use item 86326. Limit of one (1) per day. (See explanatory notes N.1 and N.2) Benefit: \$270.05</p>
† 86324	<p>Surgical removal of a tooth or tooth fragment requiring both removal of bone and tooth division. 1st tooth extracted. Inclusive of local anaesthesia and routine post-operative care. For additional surgical extractions on the same day, use item 86326. Limit of one (1) per day. (See explanatory notes N.1 and N.2) Benefit: \$334.30</p>
† 86326	<p>Additional extraction requiring surgical removal of a tooth or tooth fragment. To be used for additional surgical extractions on the same day in conjunction with items 86322, 86323 or 86324. (See explanatory notes N.1 and N.2) Benefit: \$208.45</p>
SURGERY FOR PROSTHESES	
† 86331	<p>Alveolectomy - per segment Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2) Benefit: \$128.45</p>
† 86332	<p>Ostectomy - per jaw Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2) Benefit: \$354.70</p>
† 86337	<p>Reduction of fibrous tuberosity Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2) Benefit: \$190.65</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86338	Reduction of flabby ridge - per segment Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2) Benefit: \$95.85
† 86341	Removal of hyperplastic tissue Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2) Benefit: \$209.75
† 86343	Repositioning of muscle attachment Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2) Benefit: \$258.85
† 86344	Vestibuloplasty Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2) Benefit: \$651.05
† 86345	Vestibuloplasty with skin or mucosal graft Includes insertion of sutures, normal post-operative care and suture removal. Extraction items to be claimed separately. (See explanatory notes N.1 and N.2) Benefit: \$651.05
GENERAL SURGICAL	
† 86371	Removal of tumour, cyst or scar – cutaneous, subcutaneous or in mucous membrane. Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$157.75
† 86373	Removal of tumour, cyst or scar involving muscle, bone or other deep tissue. Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$559.20
† 86375	Surgery to salivary duct Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$492.40
† 86376	Surgery to salivary gland Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$166.90
† 86377	Removal or repair of soft tissue (not elsewhere defined) Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$207.05
† 86378	Surgical removal of foreign body Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$117.00
† 86379	Marsupialisation of cyst Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$249.25

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
	OTHER SURGICAL PROCEDURES
† 86381	Surgical exposure of unerupted tooth Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$266.90
† 86382	Surgical exposure and attachment of device for orthodontic traction Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$302.75
† 86384	Repositioning of displaced tooth/teeth - per tooth Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$195.30
† 86385	Surgical repositioning of unerupted tooth Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$302.75
† 86386	Splinting of displaced tooth/teeth - per tooth Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$203.65
† 86387	Replantation and splinting of a tooth Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$393.80
† 86388	Transplantation of tooth or tooth bud Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$451.90
† 86389	Surgery to isolate and preserve neurovascular tissue Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$144.40
† 86391	Frenectomy Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$180.50
† 86392	Incision and drainage of abscess or cyst Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$94.75
† 86393	Surgery involving the maxillary antrum Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$650.55
† 86394	Surgery for osteomyelitis Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$394.85

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86395	Repair of nerve trunk Includes insertion of sutures, normal post-operative care and suture removal. (See explanatory notes N.1 and N.2) Benefit: \$792.85
SUBGROUP 5 - ENDODONTICS	
PULP AND ROOT CANAL TREATMENTS	
† 86411	Direct pulp capping (See explanatory notes N.1 and N.2) Benefit: \$35.50
† 86412	Incomplete endodontic therapy (inoperable or fractured) (See explanatory notes N.1 and N.2) Benefit: \$146.55
† 86414	Pulpotomy (See explanatory notes N.1 and N.2) Benefit: \$67.70
† 86415	Complete chemo-mechanical preparation of root canal - one canal (See explanatory notes N.1 and N.2) Benefit: \$304.30
† 86416	Complete chemo-mechanical preparation of root canal - each additional canal on the same tooth. To be claimed in conjunction with item 86415. (See explanatory notes N.1 and N.2) Benefit: \$155.55
† 86417	Root canal obturation - one canal (See explanatory notes N.1 and N.2) Benefit: \$304.30
† 86418	Root canal obturation - each additional canal on the same tooth To be claimed in conjunction with item 86417. (See explanatory notes N.1 and N.2) Benefit: \$155.55
† 86419	Extirpation of pulp or debridement of root canal(s) - emergency or palliative (See explanatory notes N.1 and N.2) Benefit: \$127.10
PERIRADICULAR SURGERY	
† 86431	Periapical curettage - per root (See explanatory notes N.1 and N.2) Benefit: \$258.45
† 86432	Apicectomy - per root Includes curettage. (See explanatory notes N.1 and N.2) Benefit: \$258.85
† 86433	Exploratory periradicular surgery Limit of one (1) per 12 month period. Not claimable if services for the following items 86431, 86432, 86434, 86436, 86437 and 86438 are provided on the same day. (See explanatory notes N.1 and N.2) Benefit: \$122.15
† 86434	Apical seal - per canal Included apicectomy and periapical curettage. (See explanatory notes N.1 and N.2) Benefit: \$408.45

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86436	Sealing of perforation (See explanatory notes N.1 and N.2) Benefit: \$239.65
† 86437	Surgical treatment and repair of an external root resorption - per tooth (See explanatory notes N.1 and N.2) Benefit: \$393.00
† 86438	Hemisection (See explanatory notes N.1 and N.2) Benefit: \$287.60
OTHER ENDODONTIC SERVICES	
† 86445	Exploration for a calcified root canal - per canal (See explanatory notes N.1 and N.2) Benefit: \$108.20
† 86451	Removal of root filling - per canal (See explanatory notes N.1 and N.2) Benefit: \$108.20
† 86452	Removal of cemented root canal post or post crown (See explanatory notes N.1 and N.2) Benefit: \$101.45
† 86453	Removal or bypassing fractured endodontic instrument (See explanatory notes N.1 and N.2) Benefit: \$94.75
† 86455	Additional visit for irrigation and/or dressing of the root canal system - per tooth Cannot be paid with items 86415, 86416, 86417 or 86418 on the same day. (See explanatory notes N.1 and N.2) Benefit: \$108.20
† 86457	Obturation of resorption defect or perforation (non-surgical) (See explanatory notes N.1 and N.2) Benefit: \$108.20
† 86458	Interim therapeutic root filling - per tooth Limit of three (3) in a 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$121.75
SUBGROUP 6 - RESTORATIVE SERVICES	
METALLIC RESTORATIONS - DIRECT	
† 86511	Metallic restoration - one surface - direct (See explanatory notes N.1 and N.2) Benefit: \$80.10
† 86512	Metallic restoration - two surfaces - direct (See explanatory notes N.1 and N.2) Benefit: \$98.15
† 86513	Metallic restoration - three surfaces - direct (See explanatory notes N.1 and N.2) Benefit: \$117.05
† 86514	Metallic restoration - four surfaces - direct (See explanatory notes N.1 and N.2) Benefit: \$133.45
† 86515	Metallic restoration - five surfaces - direct (See explanatory notes N.1 and N.2) Benefit: \$152.40

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
ADHESIVE RESTORATIONS - ANTERIOR TEETH - DIRECT	
† 86521	Adhesive restoration - one surface - anterior tooth - direct Limit of five (5) single-surface adhesive restorations (86521 or 86531) per day. (See explanatory notes N.1 and N.2) Benefit: \$88.70
† 86522	Adhesive restoration - two surfaces - anterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$107.60
† 86523	Adhesive restoration - three surfaces - anterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$127.40
† 86524	Adhesive restoration - four surfaces - anterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$147.20
† 86525	Adhesive restoration - five surfaces - anterior tooth - direct (See explanatory notes N.1 and N.2) Benefit: \$205.75
ADHESIVE RESTORATIONS - POSTERIOR TEETH - DIRECT	
† 86531	Adhesive restoration - one surface - posterior tooth - direct Limit of five (5) single-surface adhesive restorations (86521 or 86531) per day. (See explanatory notes N.1 and N.2) Benefit: \$94.70
† 86532	Adhesive restoration – two surfaces – posterior tooth – direct (See explanatory notes N.1 and N.2) Benefit: \$118.80
† 86533	Adhesive restoration – three surfaces – posterior tooth – direct (See explanatory notes N.1 and N.2) Benefit: \$142.90
† 86534	Adhesive restoration – four surfaces – posterior tooth – direct (See explanatory notes N.1 and N.2) Benefit: \$161.00
† 86535	Adhesive restoration – five surfaces – posterior tooth – direct (See explanatory notes N.1 and N.2) Benefit: \$240.95
METALLIC RESTORATIONS - INDIRECT	
† 86541	Metallic restoration – one surface – indirect (See explanatory notes N.1 and N.2) Benefit: \$345.10
† 86542	Metallic restoration – two surfaces – indirect (See explanatory notes N.1 and N.2) Benefit: \$471.25
† 86543	Metallic restoration – three surfaces – indirect (See explanatory notes N.1 and N.2) Benefit: \$635.90
† 86544	Metallic restoration – four surfaces – indirect (See explanatory notes N.1 and N.2) Benefit: \$753.95
† 86545	Metallic restoration – five surfaces – indirect (See explanatory notes N.1 and N.2) Benefit: \$948.95

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
	TOOTH COLOURED RESTORATIONS - INDIRECT
† 86551	Tooth-coloured restoration – one surface – indirect (See explanatory notes N.1 and N.2) Benefit: \$575.15
† 86552	Tooth-coloured restoration – two surfaces – indirect (See explanatory notes N.1 and N.2) Benefit: \$651.85
† 86553	Tooth-coloured restoration – three surfaces – indirect (See explanatory notes N.1 and N.2) Benefit: \$824.35
† 86554	Tooth-coloured restoration – four surfaces – indirect (See explanatory notes N.1 and N.2) Benefit: \$891.45
† 86555	Tooth-coloured restoration – five surfaces – indirect (See explanatory notes N.1 and N.2) Benefit: \$948.95
	OTHER RESTORATIVE SERVICES
† 86572	Provisional (intermediate/ temporary) restoration Not claimable if services for endodontic items (86411 to 86458 inclusive) except 86419 are provided on the same day. Limit of three (3) per three month period. (See explanatory notes N.1 and N.2) Benefit: \$37.40
† 86574	Metal band The cementation of a metal band for diagnostic, protective purposes or for the placement of a provisional (intermediate) restoration. (See explanatory notes N.1 and N.2) Benefit: \$31.55
† 86575	Pin retention – per pin (See explanatory notes N.1 and N.2) Benefit: \$21.55
† 86576	Stainless steel crown (See explanatory notes N.1 and N.2) Benefit: \$220.45
† 86577	Cusp capping – per cusp (See explanatory notes N.1 and N.2) Benefit: \$23.25
† 86578	Restoration of an incisal corner – per corner (See explanatory notes N.1 and N.2) Benefit: \$23.25
† 86595	Removal of inlay/onlay (See explanatory notes N.1 and N.2) Benefit: \$108.20
† 86596	Recementing of inlay/onlay (See explanatory notes N.1 and N.2) Benefit: \$60.80
† 86597	Post – direct Insertion of a post into a prepared root canal to provide an anchor for an artificial crown or other restoration. (See explanatory notes N.1 and N.2) Benefit: \$135.45

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
SUBGROUP 7 - CROWN AND BRIDGE	
CROWNS	
† 86613	Full crown – non metallic – indirect (See explanatory notes N.1 and N.2) Benefit: \$1,371.55
† 86615	Full crown – veneered – indirect (See explanatory notes N.1 and N.2) Benefit: \$1,513.40
† 86618	Full crown – metallic – indirect (See explanatory notes N.1 and N.2) Benefit: \$1,210.70
† 86625	Core for crown including post – indirect (See explanatory notes N.1 and N.2) Benefit: \$326.30
† 86627	Preliminary restoration for crown – direct (See explanatory notes N.1 and N.2) Benefit: \$135.30
† 86629	Post and root cap – indirect (See explanatory notes N.1 and N.2) Benefit: \$331.40
TEMPORARY (PROVISIONAL) CROWN AND BRIDGE	
† 86631	Provisional crown (See explanatory notes N.1 and N.2) Benefit: \$117.00
† 86632	Provisional bridge – per pontic (See explanatory notes N.1 and N.2) Benefit: \$227.85
BRIDGES	
† 86642	Bridge pontic – direct – per pontic (See explanatory notes N.1 and N.2) Benefit: \$630.70
† 86643	Bridge pontic – indirect – per pontic (See explanatory notes N.1 and N.2) Benefit: \$1,005.80
† 86644	Semi-fixed attachment (See explanatory notes N.1 and N.2) Benefit: \$325.90
† 86645	Precision or magnetic attachment (See explanatory notes N.1 and N.2) Benefit: \$321.45
† 86649	Retainer for bonded fixture – indirect – per tooth (See explanatory notes N.1 and N.2) Benefit: \$335.50
CROWN AND BRIDGE REPAIRS AND OTHER SERVICES	
† 86651	Recementing crown or veneer (See explanatory notes N.1 and N.2) Benefit: \$90.10
† 86652	Recementing bridge or splint - per abutment (See explanatory notes N.1 and N.2) Benefit: \$102.85

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86653	Rebonding of bridge or splint where retreatment of bridge surface is required (See explanatory notes N.1 and N.2) Benefit: \$96.05
† 86655	Removal of crown (See explanatory notes N.1 and N.2) Benefit: \$60.95
† 86656	Removal of bridge or splint (See explanatory notes N.1 and N.2) Benefit: \$142.00
† 86658	Repair of crown, bridge or splint - indirect Inclusive of labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$358.90
† 86659	Repair of crown, bridge or splint - direct (See explanatory notes N.1 and N.2) Benefit: \$261.00
IMPLANT PROSTHESES	
† 86661	Fitting of implant abutment - per abutment (See explanatory notes N.1 and N.2) Benefit: \$589.50
† 86663	Removal of implant (See explanatory notes N.1 and N.2) Benefit: \$450.55
† 86664	Fitting of bar for denture - per abutment (See explanatory notes N.1 and N.2) Benefit: \$711.90
† 86666	Prosthesis with metal frame attached to implants - per tooth (See explanatory notes N.1 and N.2) Benefit: \$565.55
† 86669	Removal and reattachment of prosthesis fixed to implant(s) - per implant (See explanatory notes N.1 and N.2) Benefit: \$172.55
† 86671	Full crown attached to osseointegrated implant - non metallic - indirect (See explanatory notes N.1 and N.2) Benefit: \$1,371.55
† 86672	Full crown attached to osseointegrated implant - veneered - indirect (See explanatory notes N.1 and N.2) Benefit: \$1,513.40
† 86673	Full crown attached to osseointegrated implant - metallic - indirect (See explanatory notes N.1 and N.2) Benefit: \$1,210.70
† 86679	Surgical implant guide (See explanatory notes N.1 and N.2) Benefit: \$295.60
† 86684	Insertion of first stage of two-stage endosseous implant - per implant Includes cost of hardware. (See explanatory notes N.1 and N.2) Benefit: \$1,288.50

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86688	<p>Insertion of one-stage endosseous implant - per implant Includes cost of hardware. (See explanatory notes N.1 and N.2) Benefit: \$1,414.60</p>
† 86691	<p>Second stage surgery of two stage endosseous implant - per implant Includes the cost of hardware. (See explanatory notes N.1 and N.2) Benefit: \$435.90</p>
SUBGROUP 8 - PROSTHODONTICS	
DENTURES AND DENTURE COMPONENTS	
† 86711	<p>Complete maxillary denture Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20) Benefit: \$732.50</p>
† 86712	<p>Complete mandibular denture Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20) Benefit: \$732.50</p>
† 86716	<p>Metal palate or plate Additional to items 86711, 86712 or 86719 (See explanatory notes N.1 and N.2) Benefit: \$242.45</p>
† 86719	<p>Complete maxillary and mandibular dentures Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20) Benefit: \$1,298.90</p>
† 86721	<p>Partial maxillary denture - resin base Base amount only. To be claimed in conjunction with items 86733 for each additional tooth. Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20) Benefit: \$326.25</p>
† 86722	<p>Partial mandibular denture - resin base Base amount only. To be claimed in conjunction with item 86733 for each additional tooth. Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20) Benefit: \$326.25</p>
† 86727	<p>Partial maxillary denture - cast metal framework (includes provision of casting) Inclusive of clasps, retainers and occlusal rests. Base amount only. To be claimed in conjunction with item 86733 for each additional tooth and item 86739 for each metal backing Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20) Benefit: \$1,080.70</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86728	<p>Partial mandibular denture - cast metal framework (includes provision of casting) Inclusive of clasps, retainers and occlusal rests. Base amount only. To be claimed in conjunction with item 86733 for each additional tooth and item 86739 for each metal backing Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20) Benefit: \$1,080.70</p>
† 86731	<p>Retainer - per tooth Additional to items 86721 and 86722. (See explanatory notes N.1 and N.2) Benefit: \$33.85</p>
† 86732	<p>Occlusal rest - per rest Additional to items 86721 and 86722. (See explanatory notes N.1 and N.2) Benefit: \$16.45</p>
† 86733	<p>Tooth/Teeth (Partial denture) An item to describe each tooth added to the base of new partial denture. The number of teeth should be indicated. To be claimed with items 86721, 86722, 86727 or 86728. Limit of twelve (12) per base. (See explanatory notes N.1 and N.2) Benefit: \$34.95</p>
† 86735	<p>Precision or magnetic attachment (See explanatory notes N.1 and N.2) Benefit: \$195.65</p>
† 86736	<p>Immediate tooth replacement - per tooth (See explanatory notes N.1 and N.2) Benefit: \$7.00</p>
† 86737	<p>Resilient lining (See explanatory notes N.1 and N.2) Benefit: \$145.20</p>
† 86738	<p>Wrought bar A wrought bar joining sections of a partial prosthesis. (See explanatory notes N.1 and N.2) Benefit: \$135.30</p>
† 86739	<p>Metal Backing - per backing An extension of the casting of a cast metal partial denture to provide a backing for the denture tooth. The number of backings should be indicated. To be claimed with items 86727 or 86728. (See explanatory notes N.1 and N.2) Benefit: \$61.15</p>
DENTURE MAINTENANCE	
† 86741	<p>Adjustment of a denture Adjustment of a denture to improve comfort and function. This item cannot be claimed for routine adjustments following the insertion of a new denture or maintenance or repair of an existing denture. (See explanatory notes N.1 and N.2) Benefit: \$40.10</p>
† 86743	<p>Relining - complete denture – processed For soft relines, use items 86743 and 86737. (See explanatory notes N.1 and N.2) Benefit: \$371.00</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
† 86744	Relining - partial denture – processed For soft relines, use items 86744 and 86737. (See explanatory notes N.1 and N.2) Benefit: \$288.40
† 86745	Remodelling- complete denture (See explanatory notes N.1 and N.2) Benefit: \$492.70
† 86746	Remodelling - partial denture (See explanatory notes N.1 and N.2) Benefit: \$393.00
† 86751	Relining - complete denture - direct Chair-side only. Either hard or soft material. (See explanatory notes N.1 and N.2) Benefit: \$172.55
† 86752	Relining - partial denture - direct (See explanatory notes N.1 and N.2) Benefit: \$135.15
† 86753	Cleaning and polishing of pre-existing denture Limit of one (1) per two year period. (See explanatory notes N.1 and N.2) Benefit: \$43.30
DENTURE REPAIRS	
† 86761	Reattaching pre-existing tooth or clasp to denture Includes labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$110.70
† 86762	Replacing clasp on denture (See explanatory notes N.1 and N.2) Benefit: \$115.65
† 86763	Repairing broken base of a complete denture Includes labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$99.90
† 86764	Repairing broken base of a partial denture Includes labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$110.70
† 86765	Replacing first tooth on denture (See explanatory notes N.1 and N.2) Benefit: \$115.65
† 86767	Any repair or tooth replacement in addition to other repairs, alterations or other modifications for same denture on same day Includes labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$45.75
† 86768	Adding tooth to partial denture to replace an extracted or decoronated tooth - per tooth (See explanatory notes N.1 and N.2) Benefit: \$117.05
† 86769	Repair or addition to metal casting (See explanatory notes N.1 and N.2) Benefit: \$140.00

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
	OTHER PROSTHODONTIC SERVICES
† 86771	Tissue conditioning treatment prior to impressions Limit of five (5) per 3 month period (See explanatory notes N.1 and N.2) Benefit: \$53.15
† 86772	Splint – resin – indirect (See explanatory notes N.1 and N.2) Benefit: \$287.60
† 86773	Splint – metal – indirect (See explanatory notes N.1 and N.2) Benefit: \$287.60
† 86776	Impression where required for denture repair/modification (See explanatory notes N.1 and N.2) Benefit: \$35.35
† 86777	Identification Marking a dental appliance with a patient's name or other form of enduring patient identification. (See explanatory notes N.1 and N.2) Benefit: \$28.30
	SUBGROUP 9 - ORTHODONTICS
	REMOVABLE APPLIANCES
† 86811	Passive removable appliance – per arch (See explanatory notes N.1 and N.2) Benefit: \$335.50
† 86821	Active removable appliance – per arch (See explanatory notes N.1 and N.2) Benefit: \$651.85
† 86823	Functional orthopaedic appliance (See explanatory notes N.1 and N.2) Benefit: \$498.45
	FIXED APPLIANCES
† 86829	Partial banding – per arch (See explanatory notes N.1 and N.2) Benefit: \$613.50
† 86831	Full arch banding – per arch (See explanatory notes N.1 and N.2) Benefit: \$1,682.05
† 86862	Bonding of attachment for application of orthodontic force (See explanatory notes N.1 and N.2) Benefit: \$124.65
	SUBGROUP 10 - GENERAL SERVICES
	EMERGENCIES
† 86911	Palliative care Interim care to relieve pain, infection, bleeding or other problems not associated with other treatment. (See explanatory notes N.1 and N.2) Benefit: \$69.85

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS	
	DRUG THERAPY
† 86926	<p>Individually made tray - medicaments A tray made for the application of medicaments to the teeth or supporting tissues. Not to be claimed for bleaching. (See explanatory notes N.1 and N.2) Benefit: \$121.75</p>
† 86927	<p>Provision of medication/ medicament The supply, prescription or administration of appropriate medications and medicaments required for dental treatment. Limit of one (1) per three month period. (See explanatory notes N.1 and N.2) Benefit: \$21.15</p>
	ANAESTHESIA AND SEDATION
† 86949	<p>Treatment under general anaesthesia A specialist anaesthetist must administer the anaesthetic. (See explanatory notes N.1 and N.2) Benefit: \$127.70</p>
	OCCLUSAL THERAPY
† 86963	<p>Clinical occlusal analysis including muscle and joint palpation Limit of one (1) per three year period. (See explanatory notes N.1 and N.2) Benefit: \$94.75</p>
† 86964	<p>Registration and mounting of casts for occlusal analysis Limit of one (1) per three year period. (See explanatory notes N.1 and N.2) Benefit: \$71.85</p>
† 86965	<p>Occlusal splint (See explanatory notes N.1 and N.2) Benefit: \$591.45</p>
† 86966	<p>Adjustment of pre-existing occlusal splint - per visit (See explanatory notes N.1 and N.2) Benefit: \$70.55</p>
† 86968	<p>Occlusal adjustment following occlusal analysis - per visit (See explanatory notes N.1 and N.2) Benefit: \$99.40</p>
† 86971	<p>Adjunctive physical therapy for temporomandibular joint and associated structures Limit of four (4) per 12 month period. (See explanatory notes N.1 and N.2) Benefit: \$57.55</p>
† 86972	<p>Repair/addition – occlusal splint (See explanatory notes N.1 and N.2) Benefit: \$169.35</p>
	MISCELLANEOUS
† 86981	<p>Splinting and stabilisation - direct - per tooth (See explanatory notes N.1 and N.2) Benefit: \$94.75</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL SPECIALISTS

† 86986	Post-operative care where not otherwise included In normal circumstances, dental specialists provide post-operative care following dental treatment. However, where a patient requires unforeseen post-operative care or is seen by a dental specialist who did not provide the initial treatment, this item can be used. Limit of two (2) per 12 month period (See explanatory notes N.1 and N.2) Benefit: \$67.70
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Schedule of Dental Services

Services by

Eligible Dental Prosthetists

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL PROSTHETISTS	
GROUP N3 - SERVICES PROVIDED BY ELIGIBLE DENTAL PROSTHETISTS	
SUBGROUP 1 - DIAGNOSTIC SERVICES	
EXAMINATIONS AND DIAGNOSTIC SERVICES	
† 87011	<p>Initial denture examination</p> <p>Assessment of any existing dentures and any teeth, supporting tissues and oral tissues in order to construct a removable dental prosthesis or refer to an appropriate clinician. This assessment includes the recording an appropriate medical history and any other relevant information.</p> <p>Limit of one (1) per provider every 2 years. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$36.45</p>
† 87014	<p>Consultation</p> <p>A consultation to seek advice or discuss treatment options regarding removable dental prosthesis. This consultation includes the recording an appropriate medical history and any other relevant information.</p> <p>(See explanatory notes N.1 and N.2)</p> <p>Benefit: \$29.40</p>
† 87071	<p>Diagnostic model - per model</p> <p>(See explanatory notes N.1 and N.2)</p> <p>Benefit: \$41.70</p>
SUBGROUP 2 - PROSTHODONTICS	
DENTURES AND DENTURE COMPONENTS	
† 87711	<p>Complete maxillary denture</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20)</p> <p>Benefit: \$659.30</p>
† 87712	<p>Complete mandibular denture</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20)</p> <p>Benefit: \$659.30</p>
† 87716	<p>Metal palate or plate</p> <p>Additional to items 87711, 87712 or 87719. (See explanatory notes N.1 and N.2)</p> <p>Benefit: \$242.45</p>
† 87719	<p>Complete maxillary and mandibular dentures</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20)</p> <p>Benefit: \$1,169.05</p>
† 87721	<p>Partial maxillary denture - resin base</p> <p>Base amount only. To be claimed in conjunction with item 87733 for each additional tooth.</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period. (See explanatory notes N.1 and N.2, in particular page 20)</p> <p>Benefit: \$291.30</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL PROSTHETISTS	
† 87722	<p>Partial mandibular denture – resin base</p> <p>Base amount only. To be claimed in conjunction with item 87733 for each additional tooth.</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period.</p> <p>(See explanatory notes N.1 and N.2, in particular page 20)</p> <p style="text-align: right;">Benefit: \$291.30</p>
† 87727	<p>Partial maxillary denture – cast metal framework (includes provision of casting)</p> <p>Inclusive of clasps, retainers and occlusal rests.</p> <p>Base amount only. To be claimed in conjunction with item 87733 for each additional tooth and item 87739 for each metal backing</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period.</p> <p>(See explanatory notes N.1 and N.2, in particular page 20)</p> <p style="text-align: right;">Benefit: \$1,002.50</p>
† 87728	<p>Partial mandibular denture – cast metal framework (includes provision of casting)</p> <p>Inclusive of clasps, retainers and occlusal rests.</p> <p>Base amount only. To be claimed in conjunction with item 87733 for each additional tooth and item 87739 for each metal backing</p> <p>Limit of one new set of dentures per patient every eight (8) years. In exceptional circumstances, a patient may receive a second set of new dentures during the eight year period.</p> <p>(See explanatory notes N.1 and N.2, in particular page 20)</p> <p style="text-align: right;">Benefit: \$1,002.50</p>
† 87731	<p>Retainer – per tooth</p> <p>Additional to items 87721 and 87722</p> <p>(See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$30.45</p>
† 87732	<p>Occlusal rest</p> <p>Additional to items 87721 and 87722</p> <p>(See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$14.80</p>
† 87733	<p>Tooth/Teeth (Partial denture)</p> <p>An item to describe each tooth added to the base of new partial denture. The number of teeth should be indicated. To be claimed with items 87721, 87722, 87727 or 87728.</p> <p>Limit of twelve (12) per base</p> <p>(See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$31.60</p>
† 87736	<p>Immediate tooth replacement - per tooth</p> <p>(See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$6.25</p>
† 87737	<p>Resilient lining</p> <p>(See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$130.65</p>
† 87738	<p>Wrought bar</p> <p>A wrought bar joining sections of a partial prosthesis.</p> <p>(See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$121.80</p>
† 87739	<p>Metal Backing – per backing</p> <p>An extension of the casting of a cast metal partial denture to provide a backing for the denture tooth. The number of backings should be indicated. To be claimed with items 87727 or 87728.</p> <p>(See explanatory notes N.1 and N.2)</p> <p style="text-align: right;">Benefit: \$55.00</p>

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL PROSTHETISTS	
DENTURE MAINTENANCE	
† 87741	Adjustment of pre-existing denture Adjustment of a denture to improve comfort and function. This item cannot be claimed for routine adjustments following the insertion of a new denture or maintenance or repair of an existing denture. (See explanatory notes N.1 and N.2) Benefit: \$36.05
† 87743	Relining – complete denture - processed For soft relines, use items 87743 and 87737. (See explanatory notes N.1 and N.2) Benefit: \$230.10
† 87744	Relining - partial denture - processed For soft relines, use items 87744 and 87737. (See explanatory notes N.1 and N.2) Benefit: \$196.10
† 87745	Remodelling - complete denture (See explanatory notes N.1 and N.2) Benefit: \$366.70
† 87746	Remodelling - partial denture (See explanatory notes N.1 and N.2) Benefit: \$309.15
† 87751	Relining - complete denture - direct Chair-side only. Either hard or soft material. (See explanatory notes N.1 and N.2) Benefit: \$125.85
† 87752	Relining - partial denture - direct (See explanatory notes N.1 and N.2) Benefit: \$106.10
† 87753	Cleaning and polishing of pre-existing denture Limit of one (1) per 2 year period. (See explanatory notes N.1 and N.2) Benefit: \$29.30
DENTURE REPAIRS	
† 87761	Reattaching pre-existing tooth or clasp to denture Includes labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$99.70
† 87762	Replacing clasp on denture (See explanatory notes N.1 and N.2) Benefit: \$104.10
† 87763	Repairing broken base of a complete denture Includes labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$89.85
† 87764	Repairing broken base of a partial denture Includes labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$99.70
† 87765	Replacing first tooth on denture (See explanatory notes N.1 and N.2) Benefit: \$104.10

To a maximum of \$4,250 in Medicare benefits per eligible patient (see explanatory notes N.1 and N.2)

DENTAL PROSTHETISTS	
† 87767	Any repair or tooth replacement in addition to other repairs, alterations or other modifications for same denture on same day Includes labour and laboratory costs. (See explanatory notes N.1 and N.2) Benefit: \$41.10
† 87768	Adding tooth to partial denture to replace an extracted or decoronated tooth - per tooth (See explanatory notes N.1 and N.2) Benefit: \$105.35
† 87769	Repair or addition to metal casting (See explanatory notes N.1 and N.2) Benefit: \$140.00
OTHER PROSTHODONTIC SERVICES	
† 87771	Tissue conditioning treatment prior to impressions Limit of five (5) per 3 month period. (See explanatory notes N.1 and N.2) Benefit: \$47.85
† 87776	Impression where required for denture repair (See explanatory notes N.1 and N.2) Benefit: \$31.75
† 87777	Identification Marking a dental appliance with a patient's name or other form of enduring patient identification. (See explanatory notes N.1 and N.2) Benefit: \$25.50