Australian Government

Department of Health

Medicare Benefits Schedule Book

Category 5

Operating from 1 July 2020

Title: Medicare Benefits Schedule Book

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

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GN.1.1 The Medicare Benefits Schedule - Introduction

Schedules of Services

Each professional service contained in the Schedule has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable).

If the service attracts an anaesthetic, the word (Anaes.) appears following the description. Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word (Assist.) in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

Higher rates of benefits are 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).

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 Category 5.

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 schedule, 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.

GN.1.2 Medicare - an outline

The Medicare Program ('Medicare') provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. The Department of Human Services administers Medicare and the payment of Medicare benefits. The major elements of Medicare are contained in the Health Insurance Act 1973, as amended, and include the following:

a. Free treatment for public patients in public hospitals.
b. 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
    i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
    ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner;
    iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
    iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient.

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.

Where a Medicare benefit has been inappropriately paid, the Department of Human Services may request its return from the practitioner concerned.

GN.1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

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.

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.

Billing practices contrary to the Act

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.

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.

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.

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

(a) No Medicare benefits will be paid for the service;

(b) The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.

(c) 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*.

Providers should be aware that the Department of Human Services 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, the Department of Human Services will take recovery action.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service. There is also a Health Practitioner Guideline for substantiating that a specific treatment was performed. These guidelines are located on the DHS website.

GN.2.4 Provider eligibility for Medicare

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:

(a) be a recognised specialist, consultant physician or general practitioner; or

(b) be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or

(c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption.

Any practitioner who does not satisfy the requirements outlined above may still practice medicine but their services will not be eligible for Medicare benefits.

NOTE: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors.

NOTE: 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 (i.e. the service is not listed in the MBS).

Non-medical practitioners

To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-88000 and 82100-82140 and 82200-82215, allied health professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners must be

(a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and

(b) registered with the Department of Human Services to provide these services.

GN.2.5 Provider Numbers

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 the Department of Human Services for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the Department of Human Services website.

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.

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.

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.

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.

GN.2.6 Locum tenens

Where a locum tenens will be in a practice for more than two weeks ***or*** in 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 the Department of Human Services (provider liaison - 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

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

(a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or

(b) they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or

(c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or

(d) they will be at a practice which is participating in the Practice Incentives Program; or

(e) 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.

GN.2.7 Overseas trained doctor

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

a. their date of registration as a medical practitioner for the purposes of the Health Insurance Act 1973; or
b. their date of permanent residency (the reference date will vary from case to case).

Exclusions - Practitioners who before 1 January 1997 had

a. registered with a State or Territory medical board and retained a continuing right to remain in Australia; or
b. 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.

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:
    i. Australian medical registration papers; and
    ii. a copy of their personal details in their passport and all Australian visas and entry stamps; and
    iii. a letter from the employer stating why the person requires a Medicare provider number and/or prescriber number is required; and
    iv. a copy of the employment contract.

GN.2.8 Contact details for the Department of Human Services

Changes to Provider Contact Details

It is important that you contact the Department of Human Services promptly of any changes to your preferred contact details. Your preferred mailing address is used to contact you about Medicare provider matters. We require requests for changes to your preferred contact details to be made by the provider in writing to the Department of Human Services at:

Medicare

GPO Box 9822

in your capital city

or

By email: medicare.prov@medicareaustralia.gov.au

You may also be able to update some provider details through HPOS
http://www.medicareaustralia.gov.au/hpos/index.jsp

MBS Interpretations

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of the Department of Human Services. Inquiries concerning matters of interpretation of MBS items should be directed to the Department of Health at Email: askmbs@health.gov.au

or by phone on 132 150

GN.3.9 Patient eligibility for Medicare

An "eligible person" is a person who resides permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. Eligible persons must enrol with Medicare before they can receive Medicare benefits.

Medicare covers services provided only in Australia. It does not refund treatment or evacuation expenses overseas.

GN.3.10 Medicare cards

The **green** Medicare card is for people permanently in Australia. Cards may be issued for individuals or families.

The **blue** Medicare card bearing the words "INTERIM CARD" is for people who have applied for permanent residence.

Visitors from countries with which Australia has a Reciprocal Health Care Agreement receive a card bearing the words "RECIPROCAL HEALTH CARE"

GN.3.11 Visitors to Australia and temporary residents

Visitors and temporary residents in Australia are not eligible for Medicare and should therefore have adequate private health insurance.

GN.3.12 Reciprocal Health Care Agreements

Australia has Reciprocal Health Care Agreements with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Norway, Italy, Malta, Belgium and Slovenia.

Visitors from these countries are entitled to medically necessary treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits and drugs under the Pharmaceutical Benefits Scheme (PBS). Visitors must enroll with the Department of Human Services to receive benefits. A passport is sufficient for public hospital care and PBS drugs.

Exceptions:

· Visitors from Ireland and New Zealand are entitled to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare cards.

· Visitors from Italy and Malta are covered for a period of six months only.

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

GN.4.13 General Practice

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 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 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.

A medical practitioner seeking recognition as an FRACGP should apply to the Department of Human Services, having completed an application form available from the Department of Human Services'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 the Department of Human Services when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on the Department of Human Services's website.

Vocational recognition of general practitioners

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 days, predominantly in general practice; and

· has met the 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 the minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

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.

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP

Tel: 1800 472 247 Email at: qicpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.gov.au

Executive Assistant, ACRRM:

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

How to apply for vocational recognition

Medical practitioners seeking vocational recognition should apply to the Department of Human Services using the approved Application Form available on the the Department of Human Services website: www.humanservices.gov.au. Applicants should forward their applications, as appropriate, to

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprac@health.gov.au

The relevant body will forward the application together with its certification of eligibility to the Department of Human Services CEO for processing.

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.

Further information on continuing medical education and quality assurance requirements should be directed to the RACGP or the ACRRM depending on the college through which the practitioner is pursuing, or is intending to pursue, continuing medical education.

Medical practitioners refused certification by the RACGP, the ACRRM or GPREC may appeal in writing to The Secretariat, General Practice Recognition Appeal Committee (GPRAC), National Registration and Accreditation Scheme Policy Section, MDP 152, Department of Health, GPO Box 9848, Canberra, ACT, 2601.

Removal of vocational recognition status

A medical practitioner may at any time request the Department of Human Services to remove their name from the Vocational Register of General Practitioners.

Vocational recognition status can also be revoked if the RACGP, the ACRRM or GPREC certifies to the Department of Human Services 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.

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-register, or for a new determination.

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

· is registered as a specialist under State or Territory law; or

· holds a fellowship of a specified specialist College and has obtained, after successfully completing an appropriate course of study, a relevant qualification from a relevant College

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*.

A relevant specialist College may also give the Department of Human Services' Chief Executive Officer a written notice stating that a medical practitioner meets the criteria for recognition.

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 the Department of Human Services' Medicare website.

Once the practitioner is recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*, Medicare benefits will be payable at the appropriate higher rate for services rendered in the relevant speciality, provided the patient has been appropriately referred to them.

Further information about applying for recognition is available at the Department of Human Services' Medicare website.

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the DHS website.

GN.5.15 Emergency Medicine

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.

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

GN.5.16 Conjoint Committee for recognising training in Micro Bypass Glaucoma Surgery (MBGS)

The Conjoint Committee comprises representatives from the Australian and New Zealand Glaucoma Society (ANZGS) and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO). For the purposes of MBS item 42504, specialists performing this procedure must have certification and training recognised by the Conjoint Committee for the Recognition of Training in Micro-Bypass Glaucoma Surgery, and the Department of Human Services notified of that recognition.

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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.

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services. Information about the form of a diagnostic imaging request can be found in **Note IN.0.1** of the Diagnostic Imaging Services Table (Category 5) and information about the form of a pathology request can be found in **Note PN.2.1** of the Pathology Services Table (Category 6).

What is a Referral?

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).

Subject to the exceptions in the paragraph below, for a valid "referral" to take place

(i) the referring practitioner must have undertaken a professional attendance with the patient and turned their mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);

(ii) the instrument of referral must be in writing as 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.

The exceptions to the requirements in paragraph above 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, for a 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 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.

Examination by Specialist Anaesthetists

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.

Who can Refer?

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.

Referrals by Dentists or Optometrists or Participating Midwives or Participating Nurse Practitioners

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

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

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

(c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for I pregnancy only or

(d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

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

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

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.

Billing

Routine Referrals

In addition to providing the usual information required to be shown on accounts, receipts or assignment forms, specialists and consultant physicians must provide the following details (unless there are special circumstances as indicated in paragraph below):-

- name and either practice address or provider number of the referring practitioner;

- date of referral; and

- period of referral (when other than for 12 months) expressed in months, eg "3", "6" or "18" months, or "indefinitely" should be shown.

Special Circumstances

(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) Emergencies

If the referral occurred in an emergency, 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 for a 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 (e.g. 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

State and Territory Governments are responsible for the provision of public hospital services to eligible persons in accordance with the National Healthcare Agreement.

Bulk Billing

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.

Period for which Referral is Valid

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

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.

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

Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, 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.

Definition of a Single Course of Treatment

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.

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.

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.

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.

Retention of Referral Letters

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.

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 2 years from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Department of Human Services CEO, to produce to a medical practitioner who is an employee of the Department of Human Services, 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.

Attendance for Issuing of a Referral

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.

Locum-tenens Arrangements

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.

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.

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.

Self Referral

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

GN.7.17 Billing procedures

The Department of Human Services website contains information on Medicare billing and claiming options. Please visit the Department of Human Services website for further information.

Bulk billing

Under the *Health Insurance Act 1973*, a bulk billing facility for professional services is available to all persons in Australia who are eligible for a benefit under the Medicare program. If a practitioner bulk bills for a service the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service cannot be raised. This includes but is not limited to:

- any consumables that would be reasonably necessary to perform the service, including bandages and/or dressings;
- record keeping fees;
- a booking fee to be paid before each service, or;
- an annual administration or registration fee.

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or 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**, **179 to 212**, **733 to 789** and **5000 to 5267** (inclusive) 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.

Where a practitioner provides a number of services (excluding operations) on the one occasion, they can choose to bulk bill some or all of those services and privately charge a fee for the other service (or services), in excess of the Medicare rebate. The privately charged fee can only be charged in relation to said service (or services). Where two or more operations are provided on the one occasion, all services must be either bulk billed or privately charged.

It should be noted that, where a service is not bulk billed, a practitioner may privately raise an additional charge against a patient, such as for a consumable. An additional charge can also be raised where a practitioner does not bulk bill a patient but instead charges a fee that is equal to the rebate for the Medicare service. For example, where a general practitioner provides a professional service to which item 23 relates the practitioner could, in place of bulk billing the patient, charge the rebate for the service and then also raise an additional charge (such as for a consumable).

GN.8.18 Provision for review of individual health professionals

The Professional Services Review (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.

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 practicing 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.

The Department of Human Services monitors health practitioners' claiming patterns. Where the Department of Human Services 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 a conduct a review and in which manner the review will be conducted. The Director is authorized to require that documents and information be provided.

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.

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.

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).

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.

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.

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 reduce 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.

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 (See general explanatory note G15.1 for more information on 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.

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:

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information is available from the PSR website - www.psr.gov.au

GN.8.19 Medicare Participation Review Committee

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences;

(b) has breached an Approved Pathology Practitioner undertaking;

(c) has engaged in prohibited diagnostic imaging practices; or

(d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

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).

GN.8.20 Referral of professional issues to regulatory and other bodies

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

i. 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; or
ii. a statement of concerns of non-compliance by a practitioner with 'professional standards'.

GN.8.21 Comprehensive Management Framework for the MBS

The Government announced the Comprehensive Management Framework for the MBS in the 2011-12 Budget to improve MBS management and governance into the future. As part of this framework, the Medical Services Advisory Committee (MSAC) Terms of Reference and membership have been expanded to provide the Government with independent expert advice on all new proposed services to be funded through the MBS, as well as on all proposed amendments to existing MBS items. Processes developed under the previously funded MBS Quality Framework are now being integrated with MSAC processes under the Comprehensive Management Framework for the MBS.

GN.8.22 Medical Services Advisory Committee

The Medical Services Advisory Committee (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.

MSAC members are appointed by the Minister and include specialist practitioners, general practitioners, health economists, a health consumer representative, health planning and administration experts and epidemiologists.

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 7550.

GN.8.23 Pathology Services Table Committee

This Pathology Services Table Committee 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) including the level of fees.

GN.9.25 Penalties and Liabilities

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.

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.

GN.10.26 Schedule fees and Medicare benefits

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.

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:

a. 75% of the Schedule fee:
    i. for professional services rendered to a 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 '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'admitted' or 'in patient');
    ii. 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. 100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner.
c. 85% of the Schedule fee, or the Schedule fee less $84.70 (indexed annually in November), whichever is the greater, for all other professional services.

Public hospital services are to be provided free of charge to eligible persons who choose to be treated as public patients in accordance with the National Healthcare Agreement.

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 (i) above) attract benefits at the 85% level.

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.

Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits.

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.

GN.10.27 Medicare safety nets

The Medicare Safety Nets provide families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net.

Original Medicare Safety Net:

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2020 is $477.90. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

Under the extended Medicare safety net (EMSN), once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided below. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2020, the threshold for singles and families that hold a Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB (A) is $692.20. The threshold for all other singles and families in 2019 is $2,169.20.

The thresholds for both safety nets are usually indexed on 1 January each year.

Individuals are automatically registered with the Department of Human Services for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from the Department of Human Services offices, or completed online at http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net.

EMSN Benefit Caps:

The EMSN benefit cap is the maximum EMSN benefit payable for that item and is paid in addition to the standard Medicare rebate. Where there is an EMSN benefit cap in place for the item, the amount of the EMSN cap is displayed in the item descriptor.

Once the EMSN threshold is reached, each time the item is claimed the patient is eligible to receive up to the EMSN benefit cap. As with the safety nets, the EMSN benefit cap only applies to out-of-hospital services.

Where the item has an EMSN benefit cap, the EMSN benefit is calculated as 80% of the out-of-pocket cost for the service. If the calculated EMSN benefit is less than the EMSN benefit cap; then calculated EMSN rebate is paid. If the calculated EMSN benefit is greater than the EMSN benefit cap; the EMSN benefit cap is paid.

For example: Item A has a Schedule fee of $100, the out-of-hospital benefit is $85 (85% of the Schedule fee). The EMSN benefit cap is $30. Assuming that the patient has reached the EMSN threshold:

o If the fee charged by the doctor for Item A is $125, the standard Medicare rebate is $85, with an out-of-pocket cost of $40. The EMSN benefit is calculated as $40 x 80% = $32. However, as the EMSN benefit cap is $30, only $30 will be paid.

o If the fee charged by the doctor for Item A is $110, the standard Medicare rebate is $85, with an out-of-pocket cost of $25. The EMSN benefit is calculated as $25 x 80% = $20. As this is less than the EMSN benefit cap, the full $20 is paid.

GN.11.28 Services not listed in the MBS

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 the Department of Human Services on 132 150.

GN.11.29 Ministerial Determinations

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)**".

GN.12.30 Professional services

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.

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 essential assistance is provided, according to accepted medical practice:-

(a) Category 1 (Professional Attendances) items except 170-172, 342-346, 820-880, 6029–6042, 6064-6075;

(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11304, 11600, 11627, 11701, 11712, 11722, 11724, 11728, 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, 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.

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.

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.

Medicare benefits are only payable for items 12306 - 12322 (Bone Densitometry) when the service is performed by a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty where the patient is referred by another medical practitioner.

GN.12.31 Services rendered on behalf of medical practitioners

Medical services in Categories 2 and 3 not included in GN.12.30 and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-

(a) the medical practitioner in whose name the service is being claimed;

(b) 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.

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. All practitioners should ensure they maintain adequate and contemporaneous records. All elements of the service must be performed in accordance with accepted medical practice.

Supervision from outside of Australia is not acceptable.

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:-

(a) established consistent quality assurance procedures for the data acquisition; and

(b) personally analysed the data and written the report.

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.

GN.12.32 Medicare benefits and vaccinations

Where a medical practitioner administers an injection for immunisation purposes on the medical practioner's own patient, Medicare benefits for that service would be payable on a consultation basis, that is, for the attendance at which the injection is given. However, the cost of the vaccine itself does not attract a Medicare rebate. The Medicare benefits arrangements cover only the professional component of the medical practitioner's service. There are some circumstances where a Medicare benefit is not payable when a medical practitioner administers an injection for immunisation purposes – please refer to example 3 below for further details.

Example 1

A patient presents to a GP to receive the influenza vaccination. The patient is not in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient for the cost of the MBS service and can charge a separate amount for the cost of the vaccine, which is not covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 2

A patient presents to a GP to receive the influenza vaccination. The patient is in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient but does not need to charge a separate amount for the cost of the vaccine, which is covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 3

A GP is employed by a State or Territory community health centre to administer vaccines and provides no additional medical services.

A Medicare benefit is not payable as the GP is providing the service under an arrangement with the State or Territory, which is prohibited under subsection 19(2) of the Health Insurance Act 1973. The service is also prohibited on the basis that it is a mass immunisation which is prohibited under subsection 19(4).

A mass immunisation is a program to inoculate people that is funded by the Commonwealth or State Government, or through an international or private organisation.

GN.13.33 Services which do not attract Medicare benefits

Services not attracting benefits

(a) telephone consultations;

(b) issue of repeat prescriptions when the patient does not attend the surgery in person;

(c) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);

(d) non-therapeutic cosmetic surgery;

(e) euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.

Medicare benefits are not payable 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).

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 service is a health screening service.

(e) the service is a pre-employment screening service

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.

Pain pumps for post-operative pain management

The cannulation and/or catheterisation of surgical sites associated with pain pumps for post-operative pain management cannot be billed under any MBS item.

The filling or re-filling of drug reservoirs of ambulatory pain pumps for post-operative pain management cannot be billed under any MBS items.

Non Medicare Services

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, an injection of blood or a blood product that is autologous.

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, the harvesting, storage, in vitro processing or injection of non-haematopoietic stem cells.

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 gastroplication, for the treatment of gastro-oesophageal reflux disease;

(b) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

(d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);

(e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;

(f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;

(g) lung volume reduction surgery, for advanced emphysema;

(h) photodynamic therapy, for skin and mucosal cancer;

(i) placement of artificial bowel sphincters, in the management of faecal incontinence;

(j) selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;

(k) specific mass measurement of bone alkaline phosphatase;

(l) transmyocardial laser revascularisation;

(m) vertebral axial decompression therapy, for chronic back pain;

(n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;

(o) vertebroplasty;

(p) extracorporeal magnetic innervation.

Health Screening Services

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

(a) multiphasic health screening;

(b) mammography screening (except as provided for in Items 59300/59303);

(c) testing of fitness to undergo physical training program, vocational activities or weight reduction programs;

(d) compulsory examinations and tests to obtain a flying, commercial driving or other licence;

(e) entrance to schools and other educational facilities;

(f) for the purposes of legal proceedings;

(g) compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

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

(a) 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 cervical screening test in a person (see General Explanatory note 12.3 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;

(b) a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;

(c) age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;

(d) 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;

(e) a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;

(f) a medical examination being a requisite for Social Security benefits or allowances;

(g) a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.

The National Policy for the National Cervical Screening Program (NCSP) is as follows:

(a) Cervical screening should be undertaken every five years in asymptomatic persons, using a primary human papillomavirus (HPV) test with partial genotyping and reflex liquid based cytology (LBC) triage;

(b) Persons who have ever been sexually active should commence cervical screening at 25 years of age;

(c) Persons aged 25 years or older and less than 70 years will receive invitations and reminders to participate in the program;

(d) Persons will be invited to exit the program by having a HPV test between 70 years or older and less than 75 years of age and may cease cervical screening if their test result is low risk;

(e) Persons 75 years of age or older who have either never had a cervical screening test or have not had one in the previous five years, may request a cervical screening test and can be screened;

(f) All persons, both HPV vaccinated and unvaccinated, are included in the program;

(g) Self collection of a sample for testing is available for persons who are aged 30 years and over and has never participated in the NCSP; or is overdue for cervical screening by two years or longer.

· Self collection must be facilitated and requested by a healthcare professional who also routinely offers cervical screening services;

· The self collection device and the HPV test, when used together, must meet the requirements of the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories Reporting Tests for the NCSP; and

(h) Persons with intermediate and higher risk screening test results should be followed up in accordance with the cervical screening pathway and the NCSP: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) – endorsed by the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Society of Gynaecologic Oncologists and the Australian Society for Colposcopy and Cervical Pathology.

Note 1: As separate items exist for routine screening, screening in specific population and investigation of persons with abnormal vaginal bleeding, treating practitioners are asked to clearly identify on the request form, if the sample is collected as part of routine screening or for another purpose (see paragraph PP.16.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: Where reflex cytology is performed following the detection of HPV in routine screening, the HPV test and the LBC test results must be issued as a combined report with the overall risk rating.

Note 3: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 - Professional Attendances and the associated explanatory notes for these items in Category 1 - Professional Attendances.

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

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

A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons:

(a) a spouse, in relation to a dependant person means:

a. a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and

b. a de facto spouse of that person.

(b) a child, in relation to a dependant person means:

a. a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

b. a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the Social Security Act 1991; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

GN.14.34 Principles of interpretation of the MBS

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.

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.

GN.14.35 Services attracting benefits on an attendance basis

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.

GN.14.36 Consultation and procedures rendered at the one attendance

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.

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.

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.

GN.14.37 Aggregate items

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.

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.

GN.14.38 Residential aged care facility

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

GN.15.39 Practitioners should maintain adequate and contemporaneous records

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.

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.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

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.

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.

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a specific treatment was performed which is located on the DHS website.

CATEGORY 5: DIAGNOSTIC IMAGING SERVICES

SUMMARY OF CHANGES FROM 01/07/2020

The 01/07/2020 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended

57351 63541 63543 63551 63554 63557 63560

The following items were increased by 1.5% for annual indexation.

Fee Amended

55028 55029 55030 55031 55032 55033 55036 55037 55038 55039 55048 55049 55054
55065 55066 55068 55070 55071 55073 55076 55079 55084 55085 55113 55114 55115
55116 55117 55118 55130 55135 55238 55244 55246 55248 55252 55274 55276 55278
55280 55282 55284 55292 55294 55296 55600 55603 55700 55703 55704 55705 55706
55707 55708 55709 55712 55715 55718 55721 55723 55725 55729 55736 55739 55759
55762 55764 55766 55768 55770 55772 55774 55812 55814 55844 55846 55848 55850
55852 55854 55856 55857 55858 55859 55860 55861 55862 55863 55864 55865 55866
55867 55868 55869 55870 55871 55872 55873 55874 55875 55876 55877 55878 55879
55880 55881 55882 55883 55884 55885 55886 55887 55888 55889 55890 55891 55892
55893 55894 55895 56001 56007 56010 56013 56016 56022 56028 56030 56036 56101
56107 56219 56220 56221 56223 56224 56225 56226 56233 56234 56237 56238 56301
56307 56401 56407 56409 56412 56501 56507 56553 56620 56622 56623 56626 56627
56628 56629 56630 56801 56807 57001 57007 57201 57341 57351 57352 57353 57354
57360 57362 57506 57509 57512 57515 57518 57521 57522 57523 57524 57527 57541
57700 57703 57706 57709 57712 57715 57721 57901 57902 57905 57907 57915 57918
57921 57924 57927 57930 57933 57939 57942 57945 57960 57963 57966 57969 58100
58103 58106 58108 58109 58112 58115 58120 58121 58300 58306 58500 58503 58506
58509 58521 58524 58527 58700 58706 58715 58718 58721 58900 58903 58909 58912
58915 58916 58921 58927 58933 58936 58939 59103 59300 59302 59303 59305 59312
59314 59318 59700 59703 59712 59715 59718 59724 59733 59739 59751 59754 59763
59903 59912 59925 59970 60000 60003 60006 60009 60012 60015 60018 60021 60024
60027 60030 60033 60036 60039 60042 60045 60048 60051 60054 60057 60060 60063
60066 60069 60072 60075 60078 60500 60503 60506 60509 60918 60927 61109 64990
64991

Amend Diagnostic Imaging Items

Minor amendment to 4 item descriptors for consistency with other items.

Amend item 57351

Amend item to correct the descriptor.

Amend Diagnostic Imaging Items

Amend 63541 and 63543 to remove "K" reference.

DIAGNOSTIC IMAGING SERVICES NOTES

IN.0.1 Diagnostic Imaging Services – 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. For further information on diagnostic imaging, visit the Department of Health's website.

IN.0.2 What is a Diagnostic Imaging Service

A diagnostic imaging service is defined in the Act as "an R-type diagnostic imaging service or an NR-type diagnostic imaging service to which an item in the DIST applies".

A diagnostic imaging service includes the diagnostic imaging procedure, which 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 as well as the report'.

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:

- 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, 59312, 59314, 60506, 60509 and 61109);

- 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 by the profession as being necessary for the appropriate treatment of the patient.

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. For NR-type services (and R-type services provided without a request under the exemption provisions - see IN.0.6 - 'Exemptions from the written request requirements for R-type diagnostic imaging services'), the clinical relevance of the service is determined by the providing practitioner.

IN.0.3 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 Services Australia in order for Medicare benefits to be payable for diagnostic imaging procedures provided at the site, or in the case of procedures reported remotely, for procedures reported for the site.

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 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.

Suspension or Cancellation

Registration will be suspended if a proprietor fails to respond to notices from Services 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 Service Australia if the registration was obtained improperly (false information supplied) or if the proprietor fails to notify Services Australia of changes to 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.

From 1 July 2010 practices applying for an LSPN will also need to apply for and be accredited under the Diagnostic Imaging Accreditation Scheme (DIAS) in order to be eligible to provide diagnostic imaging services under Medicare. Information about DIAS is available here: Diagnostic Imaging Accreditation Scheme (the DIAS).

For full details about LSPNs including how to register a practice site are available at Services Australia' website at https://www.servicesaustralia.gov.au/search/LSPN.

IN.0.4 Accreditation of Practices

Background

All practices providing diagnostic imaging services needed to be accredited under the Diagnostic Imaging Accreditation Scheme (DIAS) in order for Medicare benefits to be payable for those services.

First time accreditation

New practices entering the Scheme may choose to be accredited against either three entry-level Standards or the full suite of Standards. Practices initially choosing to be accredited against the entry level Standards have a further period of two years to become accredited against the full suite of Standards.

Re-accreditation of Practices

Practices previously accredited must seek re-accreditation against the full suite of Standards and cannot apply for re-accreditation against the entry level Standards. Accreditation against the full suite of Standards is for a four year period.

Non-Accredited Practices

Practices may choose not to be accredited and still provide diagnostic imaging services, but these services do not attract a Medicare rebate.

Practices which are not accredited under the DIAS must inform patients prior to carrying out the service that the practice is not accredited and as such the service does not attract a Medicare rebate. It is an offence under the Health Insurance Act 1973 not to do so.

The Medical Imaging Accreditation Program (MIAP)

The Royal Australian and New Zealand College of Radiologist (RANZCR) offers a voluntary accreditation program jointly with the National Association of Testing Authorities (NATA).

Practices participating in MIAP can seek recognition of their MIAP accreditation under the DIAS. This recognition will grant MIAP Practices accreditation against the full suite of Standards until the date of the expiration of the recognised MIAP accreditation. By this date Practices will need to either provide their Approved Accreditor with evidence of renewal of MIAP accreditation or have been granted accreditation against the full suite of Standard.

The Standards

The current Standards are made up of three entry level Standards and the full suite of Practice Accreditation Standards. If a practice is applying for accreditation against the entry level Standards, an accreditation decision will be made by an Approved Accreditor within 15 business days of the lodgement of an application for accreditation. If a practice is applying for accreditation against the full suite of Standards, an accreditation decision will be made by an Approved Accreditor within 30 business days of the lodgement of an application for accreditation.

From the date of being granted accreditation, the practice site can provide diagnostic imaging services under Medicare.

Entry Level Standards

- Registration and Licensing Standard (Standard 1.2)
- Radiation Safety Standard (Standard 1.3)
- Equipment Inventory Standard (Standard 1.4)

Full Suite Standards

- Part 1 - Organisational Standards
- Part 2 - Pre-procedure Standards
- Part 3 - Procedure Standards
- Part 4 - Post Procedure Standards

Applying for accreditation

Whether a practice is applying for accreditation against entry-level Standards or the full suite Standards, the application process is the same. A practice is required to submit to an Approved Accreditor either:

- an application for accreditation providing written documentary evidence of compliance with the entry level Standards or the full suite Standards; or
- written evidence of accreditation under the Medical Imaging Accreditation Program (MIAP) jointly administered by RANZCR and NATA.

Renewal of Accreditation

Practices awarded accreditation against the full suite of Standards enter the maintenance program which requires them to be re-accredited every 4 years.

Approved Accreditors

There are three Accreditation agencies approved by the Minister for Health to provide Accreditation services:

HDAA Australia (HDAA) Ph: 1800 601 696

National Association of Testing Authorities (NATA) Ph: 1800 621 666

Quality Innovation Performance (QIP) Ph: 1300 888 329

Further information can be obtained from:

Website: www.diagnosticimaging.health.gov.au

Email: DIAS@health.gov.au

Phone: 02 6289 8859

IN.0.5 Capital Sensitivity Diagnostic Imaging Equipment

Except where there is an exemption in force, Medicare benefits are not payable for diagnostic imaging services rendered using equipment, other than positron emission tomography (PET), that has exceeded is 'effective life age' for new equipment or 'maximum extended life age' for upgraded equipment as shown in the table below.

This is known as capital sensitivity and is intended to ensure that patients have access to quality diagnostic imaging services by encouraging providers to upgrade and replace aged equipment as appropriate.

Life ages of diagnostic imaging equipment

Type of Equipment	Definition of type of equipment	Effective life age for new equipment (years)	Maximum extended life age (years)
Ultrasound	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Group I1 applies	10	15
CT	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Group I2 applies	10	15
Mammography	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Subgroup 10 of Group I3 applies	10	15
Angiography	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Subgroup 13 of Group I3 applies	10	15
Other diagnostic radiology	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Subgroups 1 to 9, 12, 14, 15 or 17 of Group I3 applies	15	20
Nuclear medicine imaging (other than for PET)	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Group I4 applies (other than items 61523 to 61647)	10	15

MRI	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Group I5 applies	10	20

Capital sensitivity exemptions

A regional exemption automatically applies if services are provided in a location in Remoteness Area (RA) outer regional, remote, or very remote. Exemptions may be granted by the Department of Health (subject to particular criteria) to practices located in inner regional areas, where the location was previously under the Rural, Remote and Metropolitan Area (RRMA) classification system, RRMA4 or RRMA5.

From 1 May 2020, a further exemption is available for practices located in any region where they have not been able to replace or upgrade equipment due to delays beyond the control of the practice.

For full details about the rules for capital sensitivity, the exemptions, and the definition of upgrade, providers should access the Department of Health's website at www.health.gov.au/capitalsensitivity or send an email enquiry to capsens@health.gov.au.

IN.0.6 Requests for R-type 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 request from a requesting practitioner who determined the service was necessary.

There are exemptions to the request requirements in specified circumstances. These circumstances are detailed below under 'Exemptions from the written request requirements for R-type diagnostic imaging services'.

Form of a diagnostic imaging 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.

The *Electronic Transactions Act 1999* allows for documents required by law to be in writing, to instead be provided electronically in a range of circumstances. Diagnostic imaging requests may be made by email or other electronic medium, either directly to the imaging practice (with the patient's consent), or via the patient, as long as:

- the recipient agrees to the request being made in that form;
- it would be accessible for subsequent reference; and
- it contains the information prescribed as for requests made in writing.

There is no requirement for a diagnostic imaging request to be signed.

A written request must contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner.

A request to a medical imaging specialist for a diagnostic imaging service should include sufficient clinical information to assist the service provider to accurately provide the diagnostic imaging service requested and:

- ensure compliance with the MBS item descriptors, and

- where the requested service involves ionising radiation (x-ray, CT etc.), make a decision whether to expose the patient to radiation, consistent with the diagnostic imaging providers' obligations under the International Commission on Radiological Protection's (ICRP) doctrine of radiation protection.

Unless sufficient clinical information is provided, the requesting practitioner may be asked to provide additional information to the diagnostic imaging provider, which could result in delays for the patient.

The following should be provided on a request for a diagnostic imaging service:

- ***A clear and legible request*** - a request must be in writing, dated and be legible so that all information contained is transferred between requestor and provider without loss of content or meaning, or risk of misinterpretation. The use of abbreviations should be avoided. Where permitted, verbal referrals should ensure clear communication between the requestor and provider.

  · Under the Electronic Transactions Act 1999, this information can be provided in electronic form.

- ***Identity of the patient*** – a request should include details which confirm the identity of the patient, including their contact details.

- ***Identity of the requestor*** – a request should include the identity and contact details of the requesting practitioner, including their Medicare provider number, to ensure effective and timely communication.

- ***Clinical detail*** - a request should include a clinical justification for each examination requested and performed to support the performance of the diagnostic imaging examination.

  · Requests should contain information to enable the provider to confirm that the requested diagnostic imaging modality and examination are appropriate to that individual patient's presentation and circumstances, to answer the referrer's diagnostic question with the least number of diagnostic steps (with due regard for patient safety, radiation dose, local expertise and cost).

  · Where the request is for diagnostic imaging involving ionising radiation (e.g. x-ray, CT) the request should include clinical information for the provider to determine whether the expected clinical benefit to the patient of being exposed to diagnostic radiation outweighs the risk of radiation exposure ('justification for medical radiation exposure').

  · The provider must have sufficient information to justify and approve a medical radiation procedure. Where known, this information should include pregnancy status for women of child-bearing age.

  · Before requesting a diagnostic imaging service, the requesting practitioner must turn their mind to the clinical relevance of the request and determine that the service is necessary. For example, an ultrasound to determine the sex of a foetus is generally not a clinically relevant service, unless there is an indication this service will determine further courses of treatment (e.g. where there is a genetic risk of a sex-related disease or condition).

The requestor should consider whether:

· they are duplicating recent tests.

· the results would change the diagnosis, affect patient management or do more harm than good.

· RANZCR's Education Modules for appropriate Imaging Referrals contains decision support tools for select clinical scenarios.

· the Australian Radiation Protection and Nuclear Safety Agency's Radiation Protection of the Patient Module provides information about diagnostic imaging for medical practitioners, to ensure radiation use is justified, and may aid in communicating benefits and risks of diagnostic imaging modalities to patients.

· the benefits and risks to the patient or carer have been communicated, including any alternatives available, and

· there is information available to the patient about the tests requested. Consumer resources available include the:

  o NPS Medicine Wise Choosing Wisely program

  o Consumers Health Forum's Why do I even need this test? A Diagnostic Imaging and Informed Consent Consumer Resource

  o RANZCR's Inside Radiology website.

- **MBS requirements** - a request should meet any specific MBS item requirements. Failure to provide this information may mean that a Medicare benefit is not paid for the service.

Who may request a diagnostic imaging service?

The following practitioners may request a diagnostic imaging service:

Medical practitioners, specialists and consultant physicians

Specialists and consultant physicians can request any diagnostic imaging service (some exceptions apply, for example, obstetric ultrasound item 55712 where the requester needs to have obstetric qualifications).

Other medical practitioners can request any service and specific MRI Services – including 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

All dental practitioners may request the following items:

57509, 57515, 57521, 57523, 57527, 57901 to 57969, 58100, 58300, 58503, 58903, 59733, 59739, 59751, 60500 and 60503.

Oral and maxillofacial surgeons, prosthodontists, approved dental practitioners, dental specialists (periodontists, endodontists, pedeodontists, orthodontists) and specialists in oral medicine and oral pathology are also able to request the following items:

Oral and maxillofacial surgeons (without medical specialist registration i.e. approved dental practitioners)

55028, 55030, 55032, 56001 to 56220, 56224, 56301 to 56507, 56801 to 57007, 57341, 57362, 57703, 57709, 57712, 57715, 58103 to 58115, 58306, 58506, 58521 to 58527, 58909, 59103, 59703, 60000 to 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007 and 63334.

Note: Approved dental practitioners are dentists who were approved by the Medical Benefits (Dental Practitioners) Advisory Committee to provide oral and maxillofacial MRI services and request certain diagnostic imaging services. This committee no longer exists. Practices should contact Services Australia to determine their eligibility for providing and requesting these services.

Oral and maxillofacial surgeons (with medical specialist registration)

Oral and maxillofacial surgeons who also have a medical qualification and are registered as medical specialist can request any item in the Diagnostic Imaging Services Table, subject to their scope of practice and any clauses or requirements relevant to the individual item.

Prosthodontists

55028, 56013, 56016, 56022, 56028, 57362, 58306, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462 and 63334.

Dental specialists (periodontists, endodontists, pedeodontists, orthodontists).

56022, 57362, 58306, 61421, 61454, 61457 and 63334.

Specialists in oral medicine and/or oral pathology

55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56101, 56107, 56301, 56307, 56401, 56407, 57341, 57362, 58306, 58506, 58909, 59103, 59703, 60000 to 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007 and 63334.

Chiropractors

57712, 57715, 58100 to 58106, 58109 and 58112.

Physiotherapists and Osteopaths

57712, 57715, 58100 to 58106, 58109, 58112, 58120 and 58121.

Podiatrists

55844, 55888, 55889, 55890, 55891, 55892, 55893, 55894, 55895, 57521, 57523 and 57527.

Participating Nurse Practitioners

55036, 55066, 55070, 55071, 55076, 55600, 55768, 55812, 55844, 55848, 55850, 55852, 55856, 55857, 55858, 55859, 55860, 55861, 55862, 55863, 55864, 55865, 55866, 55867, 55868, 55869, 55870, 55871, 55872, 55873, 55874, 55875, 55876, 55877, 55878, 55879, 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894, 55895, 57509, 57515, 57521, 57523, 57527, 57703, 57709, 57712, 57715, 57721, 58503 to 58527.

Participating Midwives

57712, 57715, 57901, 57902, 57907, 57915, 57921, 58100 to 58115, 58521, 58524, 58527, 58700 and 59103.

Request 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 forms containing relevant information about a diagnostic imaging provider supplied, or made available to, a requesting practitioner by a diagnostic imaging provider must include a statement that informs the patient that the request may be taken to a diagnostic imaging provider of the patient's choice.

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 up to 10 penalty units.

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. The offence is punishable, upon conviction, by a fine of up to 10 penalty units.

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.

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.

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":

- MRI services;
- PET services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see Note IN.0.8

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:

- MRI services;
- PET services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see Note IN.0.8.

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 Note IN.0.8.

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 Services Australia website https://www.servicesaustralia.gov.au or by contacting Services Australia' Provider Eligibility Section, by email at prov.elig@servicesaustralia.gov.au or via phone on 1800 032 259 Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

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 visit the Australian College of Rural and Remote Medicine (ACRRM) website at www.acrrm.org.au, or call the ACRRM on 1800 223 226.

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 Note IN.0.8.

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 Note IN.0.8.

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, 57907, 57915, 57921, 58100 to 58115, 58521, 58524, 58527, 58700 and 59103.

To qualify for this pre-existing exemption the providing practitioner must:

- be treating his or her own patient;

- have determined that the service was necessary;

- 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;

- provide the exempted services at the practice location where the services which enabled the practitioner to qualify for the this exemption were rendered; and

- 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), at www.racgp.org.au, on 1800 472 247 or via email to racgp@racgp.org.au, or the Australian College of Rural and Remote Medicine (ACRRM), at www.acrrm.org.au or by calling 1800 223 226.

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 Note IN.0.8.

Retention of requests

A medical practitioner who has rendered an R-type diagnostic imaging service in response to a written request must retain that request for a period of two years commencing on the day on which the service was rendered.

A medical practitioner must, if requested by Services Australia, produce written requests retained by that practitioner for an R-type diagnostic imaging service as soon as practicable and in any case by the end of the day after the day on which Services Australia's request was made. An employee of Services 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 up to 10 penalty units.

The Department of Health has developed a Health Practitioner Guideline to substantiate that a valid request existed (pathology or diagnostic imaging), which is located online at www.health.gov.au.

IN.0.7 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 2 years 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.

o 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, e.g. how and when.

o For emergency services, the records must indicate the nature of the emergency.

If requested by Services Australia, records retained by a providing practitioner must be produced to an officer of Services Australia as soon as practicable but in any event within seven days after the request. Service 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.

IN.0.8 Details Required on Accounts, Receipts and Medicare Assignment of Benefit 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 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 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’.

IN.0.9 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 Services 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.

IN.0.10 Prohibited Practices

Part IIBA of the Health Insurance Act 1973 contains a number of provisions prohibiting inducements to request diagnostic imaging (and pathology) services.

Who might be affected?

Anyone who can provide or request a Medicare-funded diagnostic imaging service.

Anyone who has a relevant connection to a provider or a requester, including relatives, bodies corporate, trusts, partnerships and employees may also be affected.

What is prohibited?

- it is unlawful to ask for, accept, offer or provide a benefit, or make a threat, that is reasonably likely to induce a requester to make diagnostic imaging requests, or is related to the business of providing diagnostic imaging services.

- it is a criminal offence to ask for, accept, offer, or provide a benefit, or make a threat that is intended to induce requests to a particular provider.

- the prohibitions apply to the provision of benefits, or the making of threats, that are directed to a requester by a provider, whether directly or through another person.

A requester of diagnostic imaging services means:

- a medical practitioner;

- a dental practitioner, a chiropractor, a physiotherapist, a podiatrist or an osteopath (in relation to certain types of services prescribed in Regulations);

- a person who employs, or engages under a contract for services, one of the people mentioned above; or

- a person who exercises control or direction over one of the people mentioned above (in his or her professional capacity).

A provider of a diagnostic imaging service means:

- a person who renders that kind of service;

- a person who carries on a business of rendering that kind of service;

- a person who employs, or engages under a contract for services, one of the people detailed above; or

- a person who exercises control or direction over a person who renders that kind of service or a person who carries on a business of rendering that kind of service.

What is permitted?

Under the Act it is permitted to:

- share the profits of a diagnostic imaging business, provided the dividend is in proportion to the beneficiary's interest in the business;

- accept or pay remuneration, including salary, wages, commission, provided the remuneration is not substantially different from the usual remuneration paid to people engaged in similar employment;

- make or accept payments for property, goods or services, provided the amount paid is not substantially different from the market value of the property, goods or services;

- make or accept payments for shared property, goods or services, provided the amount paid is proportionate to the person's share of the cost of the property, goods or services and shared staff and/or equipment are not used to provide diagnostic imaging services;

- provide or accept property, goods or services, provided the benefit exchanged is not substantially different from the market value of the property, goods or services;

- provide benefits of a type determined by the Minister. These include items to support a requester to view diagnostic imaging reports, such as specially designed computer monitors. Modest gifts and hospitality may also be permitted, under certain circumstances. A full list of the Ministerial determined permitted benefits are contained in the Health Insurance (Permitted benefits — diagnostic imaging services) Determination 2018.

What are the penalties for those not complying with the provisions?

If the provisions are breached, a range of penalties would apply, depending on the kind of breach, including: civil penalties; criminal offences; referral to a Medicare Participation Review Committee (MPRC), possibly resulting in loss of access to Medicare. For further information on prohibited practices visit the Department of Health's publication 'Guidance on Laws Relating to Pathology and Diagnostic Imaging - Prohibited Practices'.

IN.0.11 Multiple Services Rules

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 IN.0.6.

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 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 e.g. 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 on the Services Australia website.

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:

- the item with the highest schedule fee retains 100% of the schedule fee; and
- 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:

- 2 or more MRI services from subgroups 12 and 13 for the same patient on the same day; and

- 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.

IN.0.12 Co-claiming consultations with DIST items – Specialist Radiologists

From 1 May 2020, specialist radiologists will no longer be able to claim a consultation in conjunction with one of the following diagnostic imaging services:

- All musculoskeletal ultrasound – Group I1, Subgroup 6 (items 55800 – 55855)
- Diagnostic radiology items as follows:

-Group I3, Subgroup 1 – Radiographic Examination of the Extremities - items 57506 to 57539
-Group I3, Subgroup 2 – Radiographic Examination of Shoulder and Pelvis - items 57700 to 57723
-Group I3, Subgroup 3 – Radiographic Examination of the Head - items 57901 to 57969
-Group I3, Subgroup 4 – Radiographic Examination of the Spine - items 58100 to 58127
-Group I3, Subgroup 5 – Bone Age Study and Skeletal Survey - items 58300 to 58308
-Group I3, Subgroup 6 – Radiographic Examination of Thoracic Region - items - 58500 to 58529
-Group I3, Subgroup 7 – Radiographic Examination of Urinary Tract - items 58700 to 58723
-Group I3, Subgroup 8 – Radiographic Examination of Alimentary Tract and Biliary System - items 58900 to 58905
-Group I3, Subgroup 9 – Radiographic Examination of Localisation of Foreign Bodies - items 59103 to 59104

Radiologists may claim consultation items when they attend the patient before, during or after the rendering of other diagnostic imaging services. Consultation items should only be claimed where the attendance on the patient is meaningful. That is:

-the radiologist utilises their medical knowledge, clinical acumen, technical skills and personal experience in clinical radiology to consult with a patient so as to alter, or potentially alter, the course of the patient's management in the best interests of the patient.
-the radiologist takes primary clinical responsibility for the management decisions made during the consultation (even if the decision is to proceed with the planned course of management).
-the consultation itself includes components of history taking; physical examination; discussion with the patient; formulation of management plans; and referral for additional opinion or tests.

Not all the components need be present in any one consultation, but presence of at least some indicates that a meaningful consultation occurred.

To claim a specialist referred consultation (item 104 or 105), the specialist radiologist must have received a valid request (not simply a request for a diagnostic imaging service) from a medical practitioner for the 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). The requesting practitioner must have undertaken a professional attendance with the

patient and turned their mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral) – see note GN.6.16.

A referral for the undertaking of a diagnostic imaging service in the absence of the other elements of a referral as noted above does not constitute a valid referral for a specialist referred consultation.

The new consultation co-claiming rules do not apply to consultant physicians, other specialists and specialist radiologists who are also specialists in other medical disciplines. However, where a specialist radiologist has more than one qualification, co-claiming is only permitted where the patient has been referred to the provider in their non-radiologist capacity.

Where a specialist or consultant physician receives a request for diagnostic imaging service only, for example, a request to a cardiologist to do an echocardiogram, a consultation should not be claimed.

In addition, consultations must not be claimed in place of claiming a diagnostic imaging service.

IN.0.13 Ultrasound

Professional supervision for ultrasound services - R-type eligible services

Ultrasound services (items 55028 to 55895) 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:

- in an emergency; or

- 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 Services Australia.

Eligibility for registration

To be eligible for registration on the Register of Accredited Sonographers held by Services Australia, the person must be accredited with the Australian Sonographer Accreditation Registry. For accreditation with the Australian Sonographer Accreditation Registry the person must hold an accredited postgraduate qualification in medical ultrasound or be studying ultrasound.

For further information, please contact Services Australia, Provider Liaison Section, on 132 150 for the cost of a local call or the Australian Sonographer Accreditation Registry through its website at www.asar.com.au.

Report requirements

The sonographer's initial and surname is to be written on the report. It is not required on billing documents. 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, Services 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", (i.e. 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

Abdominal Ultrasound Items 55036 and 55037

Medicare benefits are not payable for ultrasound items 55036 and 55037 unless a morphological assessment of the abdomen has been performed. That is, the items should be used for imaging purposes, not for non-imaging procedures such as transient elastography.

Urinary ultrasound item 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 3 – Vascular Ultrasound

General

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, the account should indicate 'bilateral' or 'left' and 'right' to enable a 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.

Deep vein thrombosis (DVT) – items 55244 and 55246

Medical practitioners referring patients for duplex ultrasound for suspected lower limb DVT (items 55244 and 55246) should read and consider the RANZCR 2015 Choosing Wisely recommendations, or such RANZCR Choosing Wisely recommendations that succeed it.

Examination of peripheral vessels

Vascular ultrasound services can be claimed in conjunction with item 11612 (Exercises study for the evaluation of lower extremity arterial disease).

Subgroup 4: Urological ultrasound Prostate 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 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.

Items 55600 applies where the service is rendered by a medical practitioner who did not assess the patient, whereas items 55603 applies 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.

Pre-requisite services

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.

Dating of pregnancy

When dating a pregnancy for the purpose of items 55700 to 55774, a patient is:

- "less than 12 weeks of gestation" means up to 11 weeks and 6 days of pregnancy;

- "12 to 16 weeks of gestation" means from 12 weeks 0 days of pregnancy up to 16 weeks plus 6 days of pregnancy (inclusive);

- "17 to 22 weeks of gestation" means from 17 weeks 0 days of pregnancy up to 22 weeks plus 6 days of pregnancy (inclusive);

- "after 22 weeks of gestation" means from 23 weeks 0 days of pregnancy onwards;

- "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.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists provides a credentialling program for providers of nuchal translucency scans.

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 requested and non-requested 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,a 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 2010 published by the Australian Bureau of Statistics (publication number 1216.0 of 2010).

Subgroup 6: Musculoskeletal (MSK)

Personal attendance

Medicare benefits are only payable for a musculoskeletal ultrasound service (items 55812 to 55895) 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 IN.0.6 for definition of remote area. Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Multiple Musculoskeletal Ultrasound Scans

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, 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 55866 or 55867, as the case may be, should be claimed once only. This is because the item descriptor for these items covers both sides. A patient should not be asked to make a second appointment in order to attract a benefit for multiple scans.

Shoulder and knee (items 55864 to 55867 and 55880 to 55883)

Benefits for shoulder and knee ultrasound items are only payable when the request is based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder or knee pain alone or other specific conditions such as meniscal and cruciate ligament tears and assessment of chondral surfaces.

IN.0.14 Restriction anaesthetic items in conjunction with item 55054

An item in Group T10 (Relative Value Guide) cannot be claimed in association with item 55054 (ultrasound when used in conjunction with procedures). Medicare benefits will continue to be available for the procedures alone and whether individual anaesthetists choose to use ultrasound to assist with those procedures is a matter of clinical judgement for those providers.

IN.0.15 Group I2 - Computed Tomography (CT)

Professional supervision

CT services (items 56001 to 57360) 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:

- to monitor and influence the conduct and diagnostic quality of the examination; and
- if necessary, to personally attend on the patient; or

(b) if the above criterion cannot be complied with

- in an emergency, or
- because of medical necessity in a remote area - refer to IN.06 for definition of remote area.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Item 57360 applies only to a CT service that is:

(a) performed under the professional supervision of a specialist or consultant physician recognised by the Conjoint Committee for the Recognition of Training in CT Coronary Angiography who is available:

- to monitor and influence the conduct and diagnostic quality of the examination; and
- if necessary, to attend on the patient personally; and

(b) reported by a specialist or consultant physician recognised by the Conjoint Committee for the Recognition of Training in CT Coronary Angiography; or

(c) if paragraphs a and b cannot be complied with

- in an emergency, or
- because of medical necessity in a remote area - refer to IN.06 for definition of remote area.

Use of PET/CT or SPECT/CT machines

CT scans rendered on Positron Emission Tomography (PET)/CT 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/region

Where regions are scanned on the one occasion which are not covered by a combination item, for example, item 56219 (scan of the spine) with item 56620 (scan of lower limbs), both examinations would attract a separate benefit.

Items covering individual contiguous regions must not be used when scans of multiple regions are performed.

More than one attendance of the patient to complete a scan

Items 56220 to 56238 (CT of the spine) and 56620 to 56630 (CT of the extremities) 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.

Scan of 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 item 56007 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:

· is under 50 years; and

· is (apart from the headache) otherwise well; and

· has no localising symptoms or signs; and

· has no history of malignancy or immunosuppression.

Scan of Spine

Multiple regions

CT items exist which separate the examination of the spine into the cervical, thoracic and lumbosacral regions.

These items are 56220 to 56238 inclusive. They include items for CT scans of two regions of the spine (56233 and 56234) and for all three regions of the spine (56237 and 56238). Restrictions apply to the following items:

- 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.

- 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.

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 (items 59724 and 59725). Where a myelogram is rendered under item 59724 and a CT is necessary, the relevant item would be scan of spine without intravenous contrast (items 56220, 56221 or 56223).

Scan of the upper abdomen and pelvis

Items 56501 and 56507 are not eligible for benefits if performed for the purpose of performing a virtual colonoscopy (otherwise known as CT colonography and CT colography). CT Colonography is covered by item 56553.

Scan of the colon (Item 56553)

In item 56553, 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, or

- multiple bowel cancers in the one person, or

- bowel cancer before the age of 50 years, or

- at least one relative with cancer of the endometrium, ovary, stomach, small bowel, ureter, biliary tract or brain, or

- at least one first-degree relative with a large number of adenomas throughout the large bowel (suspected familial adenomatis polyposis or FAP), or

- somebody in the family in whom the presence of a high-risk mutation in the adenomatis 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.

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.

CT angiography

Other than coronary arteries - items 57351 to 57354

CT angiography items 57351 apples under the circumstances specified in the item including where a service to which items 57352, 57353 or 57354 have been performed on the same patient within the previous 12 months,

Item 57352, 57353 and 57354 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.

Coronary arteries – item 57360

Payment of Medicare rebates for item 57360 is limited to specialists or consultant physicians who have fulfilled the training and credentialing requirements developed by the Conjoint Committee for the Recognition of Training in CT Coronary Angiography (CTCA).

Pulmonary Embolism (PE) – Item 57351

Medical practitioners requesting imaging for suspected PE (item 57351) should read and consider the RANZCR 2015 ChoosingWisely recommendations, or such clinical RANZCR Choosing Wisely recommendations as succeed it.

IN.0.16 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, i.e. the image, reading and report. Separate benefits are not payable for individual components of the service, e.g. 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 an 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 58121) 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.

Images produced using Dual Energy X-ray Absorptiometry (DEXA) equipment

X-ray items of the spine 58100 to 58121 and hip 57712 cannot be claimed when images are produced using Dual Energy X-ray Absorptiometry (DEXA) equipment. DEXA should be claimed under General Medical Services Table items 12306 to 12322.

Subgroup 1 – Radiographic examination of the extremities

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 e.g. L and R hand, or hand and humerus.

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.

Item 58112 - spine, two regions

Where item 58112 is rendered (spine, two regions), the item numbers for the regions of the spine being studied must be specified (i.e. 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.

Item 58115 - spine, three region

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.

Item 58115 and 58108 - spine, three and four regions – request by medical practitioner

Three and four region radiographic examinations items 58115 and 58108 only apply when requested by a medical practitioner.

Items 58120 and 58121 - spine, three and four regions – request by non-medical practitioner

Items 58120 and 58121 apply to physiotherapists and osteopaths who request a three or four region x-ray. Benefits are payable for one of these items only per patient per calendar year.

Subgroup 8: Radiographic examination of alimentary tract and biliary system

Plain abdominal film - items 58900 and 58903

Benefits are not payable for items 58900 and 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 payable 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.

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:

- 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
- if paragraph (a) cannot be complied with:
- in an emergency; or
- 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 IN.0.16). Where it is necessary to render a CT and a myelogram, CT items 56220, 56221 and 56223 would apply.

Subgroup 13: Angiography

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 DSA, benefits are payable for a maximum of one DSA item (from Items 60000 to 60069). For selective DSA - one DSA item (from 60000 to 60069) and one 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 - 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 59970 apply. A report is not required for these services.

IN.0.17 Group I4 - Nuclear Medicine Imaging

General

Benefits for a nuclear scanning service (other than PET) are only payable when the service is performed:

- by a credentialed specialist or consultant physician, or by a person acting on behalf of the specialist; and
- the final report of the service is compiled by the specialist or consultant physician who performed the preliminary examination of the patient and the estimation and administration of the dosage.

Additional benefits will only be attracted for specialist physician or consultant physician attendance under Category 1 of the Schedule where there is a request for a full medical examination accompanied by a referral letter or note of referral.

Credentialling for nuclear medicine imaging services

Payment of Medicare rebates for nuclear medicine imaging services is limited to specialists or consultant physicians who are credentialled by the Joint Nuclear Medicine Credentialling and Accreditation Committee of the Royal Australian College of Physicians (RACP) and RANZCR.

The scheme was 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.

Temporary Nuclear Medicine Items

Nuclear medicine items 61311, 61332, 61333, 61336, 61337, 61341 and 61344 may only be used during specified time periods, following a valid request for the equivalent nuclear medicine imaging item on which it is based. The items were available for a period from 14 September 2019 until 20 December 2019.

In the event that there is a future national shortage in the supply of technetium, these items may again become available. Announcements about the commencement of temporary nuclear medicine items will be published on the Department of Health's Nuclear Medicine and Positron Emission Tomography (PET) webpage.

Radiopharmaceuticals

The schedule fees for nuclear medicine imaging services incorporate the costs of radiopharmaceuticals.

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.

Myocardial perfusion - items 61306 and 61307

Items 61306 and 61307 refer to all myocardial perfusion studies involving two or more sets of imaging times related to an individual patient referral. This includes stress/rest, stress/re-injection, stress/rest and re-injection thallium studies, one or two-day technetium-based perfusion agent protocols, mixed technetium-based perfusion agent/thallium protocols and the use of gated SPECT when undertaken.

Pulmonary Embolism (PE) – items 61328, 61340 and 61348

Medical practitioners requesting imaging for suspected PE should read and consider the RANZCR 2015 Choosing Wisely recommendations, or such clinical RANZCR Choosing Wisely recommendations as succeed it.

Hepatobiliary study (pre-treatment) - item 61360

Item 61360 - the standard hepatobiliary item - also includes allowance of the pre-procedural cholagogue 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 cholagogue 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.

Positron Emission Tomography (PET) - items 61523 to 61647

General

Payment of Medicare rebates for PET services is limited to credentialled specialists or consultant physicians who meet eligibility requirements in the Diagnostic Imaging Services Table Regulations. PET services must be:

- performed under the supervision of:

  · specialist or consultant physician credentialled under the Joint Nuclear Medicine Specialist Credentialling Program for the Recognition of the Credentials of Nuclear Medicine Specialists for Positron Emission Tomography overseen by the Joint Nuclear Medicine Credentialling and Accreditation Committee of the RACP and RANZCR; or

  · practitioner who is a Fellow of either the RACP or RANZCR, and who, prior to 1 November 2011, reported 400 or more studies forming part of PET services for which a Medicare benefit was payable, and who holds a current license from the relevant State radiation licensing body to prescribe and administer the intended PET radiopharmaceuticals to humans;

- provided in a comprehensive facility that can provide a full range of diagnostic imaging services (including PET, CT, X-Ray and diagnostic ultrasound) and cancer treatment services (including chemotherapy, radiation oncology and surgical oncology) at the one site;

- provided using equipment that meets the Requirements for PET Accreditation (Instrumentation & Radiation Safety) 3nd Edition (2017) issued by the Australian and New Zealand Society of Nuclear Medicine Inc; and

- only provided following referral from a recognised specialist or consultant physician.

All PET providers must complete a specific PET provider Statutory Declaration prior to being eligible to claim Medicare rebates. Statutory declarations can be obtained directly from Services Australia.

Whole body FDG PET

In patients with Hodgkin and non- Hodgkin lymphoma (excluding indolent non- Hodgkin lymphoma), whole body FDG PET studies should not to be used for surveillance nor for assessment of patients with suspected (as opposed to confirmed) disease recurrence.

Whole body FDG PET studies should be used as an alternative rather than additional to conventional CT scanning.

IN.0.18 Group I5 - Magnetic Resonance Imaging

Itemisation

Items in Group I5 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

Items in Subgroups 1 to 21 of Group I5 (other than items 63541 to 63544) apply 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.

Items 63395 to 63397 and the items in Subgroups 19, 20 and 21 (other than items 63455 and 63461) of Group I5 apply to a MRI 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 partial eligible equipment.

Items in Subgroup 22 of Group I5 apply to a MRI or MRA service performed:

a. on request by a medical practitioner, 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 or partial eligible equipment.

Items in Subgroups 33 and 34 of Group I5 apply to a MRI service performed

a. on request by a medical practitioner other than a 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 or partial eligible equipment.

Prostate Multiparametric MRI items 63541 to 63544 apply to a service performed:

a. at the request of a specialist in the speciality of urology, radiation oncology, or medical oncology; and

b. in a permissible circumstance; and

c. using:

- eligible equipment; or
- partial eligible equipment.

Requests

A request must identify the clinical indications for the service.

MRI services can only be requested by a recognised specialist medical practitioner or consultant physician for the purposes of the Health Insurance Act 1973. However, there are exceptions to this provision for a limited number of MRI services:

- 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); and

- 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; and

- items in subgroup 33 and 34 may only be requested by a medical practitioner other than a specialist or a consultant physician.

For cardiac MRI items 63395 and 63397 (scan for diagnosis of arrhythmogenic right ventricular cardiomyopathy (ARVC)), the request must specify that ARVC is suspected on the basis of diagnostic criteria endorsed by the Cardiac Society of Australia and New Zealand (CSANZ), in force at the time the service is requested.

Permissible circumstances for performance of service

Benefits are only payable for MRI when performed as follows:

a. both:

- 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; and
- reported by an eligible provider; or

b. if paragraph (a) is not complied with:

- in an emergency; or
- because of medical necessity, in a remote location (refer to IN.0.7.)

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Eligible providers

For items in Group I5 (excluding cardiac MRI items 63395 to 63397), an eligible provider is a specialist in diagnostic radiology who satisfies the Chief Executive Medicare (Services Australia) that he or she is a participant of the RANZCR Quality and Accreditation Program.

For cardiac MRI items 63395 to 63397, an eligible provider is a specialist in diagnostic radiology or a consultant physician, who is recognised by the Conjoint Committee for Certification in Cardiac MRI. The conjoint committee is comprised of specialists from RANZCR and the Cardiac Society of Australia and New Zealand (CSANZ).

Eligible equipment is equipment which:

a. is located at premises of a comprehensive practice; and

b. is made available to the practice by a person:

- who is subject to a deed with the Commonwealth that relates to the equipment; and
- for whom the deed has not been terminated; and

c. is not identified as partial eligible equipment in the deed

Partial eligible equipment is equipment which:

a. is located at premises of a comprehensive practice; and

b. is made available to the practice by a person:

- who is subject to a deed with the Commonwealth that relates to the equipment; and
- for whom the deed has not been terminated; and

c. is identified as partial eligible equipment in the deed

The location of Medicare-eligible MRI machines is available at the Department of Health's website at http://www.health.gov.au.

Number of eligible services

Services in subgroups 1, 4, 6, 8, 11 and 18 have no frequency restriction.

Item	MRI or MRA items	Limitation Period	Maximum number of services
1	63040 to 63073	12 months	3
2	63101	12 months	3
3	63125 to 63131	12 months	3
4	63161 to 63185	12 months	3
5	63219 to 63243	12 months	3
6	63271 to 63280	12 months	3
7	63322 to 63340	12 months	3
8	63361	12 months	2
9	63385 to 63391	12 months	2
10	63395	12 months	1
11	63397	36 months	1
12	63401 to 63404	12 months	3
13	63416	12 months	1
14	63425 to 63428	12 months	2
15	63454 to 63467	12 months	1
16	63547	patient's lifetime	1
17	63482	12 months	3
18	63507 to 63522 and 63551 to 63560	12 months	3

Items 63470 or 63473 in subgroup 20 may be claimed only once ever.

Items in subgroup 22 (modifying items) may only be ordered in conjunction with an eligible MRI/MRA service.

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	18/04/05
63271	16/10/05
63271	11/12/05

The following table provides examples of further dates of service would, and would not, be eligible:

Date of Service	Claimable	Why?
12/03/05	No	Between 10/12/04 and 9/12/05, the patient would have had 4 x 63271 in 12 months - 10/12/04, 12/03/05, 18/4/05 and 16/10/05
04/03/06	No	Between 5/03/05 and 4/03/06, the patient would have had 4 x 63271 in 12 months - 18/04/05, 16/10/05, 11/12/05 and 4/03/06
20/04/06	Yes	Between 21/04/05 and 20/04/06, the patient would have had 3 x 63271 in 12 months - 16/10/05, 11/12/05 and 20/04/06

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.

IN.0.19 Bulk Billing Incentive

Out-of-hospital services (except item 61369) attract higher benefits when they are bulk billed by the provider.

For other than items in Group I5 – Magnetic Resonance Imaging (MRI) - benefits for bulk billed services are payable at 95% of the schedule fee for the item. For MRI services, benefits for bulk billed services are payable at 100% of the schedule for the item.

IN.0.20 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, 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.

I1. ULTRASOUND	**1. GENERAL**
	Group I1. Ultrasound
	Subgroup 1. General
Fee 55028	Head, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55029	Head, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55030	Orbital contents, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55031	Orbital contents, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55032	Neck, one or more structures of, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55033	Neck, one or more structures of, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55036	Abdomen, ultrasound scan of (including scan of urinary tract when performed), for morphological assessment, if: (a) the service is not solely a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra; and (b) within 24 hours of the service, a service mentioned in item 55038 is not performed on the same patient by the providing practitioner (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $112.95 **Benefit:** 75% = $84.75 85% = $96.05
Fee 55037	Abdomen, ultrasound scan of (including scan of urinary tract when performed), for morphological assessment, if the service is not solely a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55038	Urinary tract, ultrasound scan of, if:

	(a) the service is not solely a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra; and (b) within 24 hours of the service, a service mentioned in item 55036 or 55065 is not performed on the same patient by the providing practitioner (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55039	Urinary tract, ultrasound scan of, if the service is not solely a transrectal ultrasonic examination of any of the following: (a) prostate gland; (b) bladder base; (c) urethra (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55048	Scrotum, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $111.15 **Benefit:** 75% = $83.40 85% = $94.50
Fee 55049	Scrotum, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55054	Ultrasonic cross-sectional echography, in conjunction with a surgical procedure (other than a procedure to which item 55848 or 55850 applies) using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15 **Extended Medicare Safety Net Cap:** $0.00
Fee 55065	Pelvis, ultrasound scan of, by any or all approaches, if: (a) the service is not solely: (i) a service to which an item in Subgroup 5 of this Group applies, or (ii) a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (b) within 24 hours of the service, a service mentioned in item 55038 is not performed on the same patient by the providing practitioner (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
Fee 55066	Breasts, both, ultrasound scan, in conjunction with a surgical procedure using interventional techniques, if: (a) the request for the scan indicates that an ultrasound guided breast intervention be performed; and

	(b) the service is not performed in conjunction with any other item in this Group (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $221.45 **Benefit:** 75% = $166.10 85% = $188.25
Fee 55068	Pelvis, ultrasound scan of, by any or all approaches, if the service is not solely a service to which an item in Subgroup 5 of this Group applies or a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.50 **Benefit:** 75% = $26.65 85% = $30.20
Fee 55070	Breast, one, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
Fee 55071	Breast, one, ultrasound scan, in conjunction with a surgical procedure using interventional techniques, if: (a) the request for the scan indicates that an ultrasound guided breast intervention be performed; and (b) the service is not performed in conjunction with any other item in this group (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $210.45 **Benefit:** 75% = $157.85 85% = $178.90
Fee 55073	Breast, one, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $34.55 **Benefit:** 75% = $25.95 85% = $29.40
Fee 55076	Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55079	Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55084	Urinary bladder, ultrasound scan of, by any or all approaches, if within 24 hours of the service, a service mentioned in item 11917, 55036, 55038, 55065, 55600 or 55603 is not performed on the same patient by the providing practitioner (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
Fee 55085	Urinary bladder, ultrasound scan of, by any or all approaches, if within 24 hours of the service, a service mentioned in item 11917, 55037, 55039, 55068, 55600 or 55603 is not performed on the same patient by the providing practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $34.55 **Benefit:** 75% = $25.95 85% = $29.40

	Group I1. Ultrasound
	Subgroup 2. Cardiac
Fee 55113	M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain, if:

	(a) the service involves all of the following: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques; (ii) real time colour flow mapping from at least 2 acoustic windows; (iii) recordings on video tape or digital media; and (b) the service is not associated with a service to which another item in this Subgroup (except items 55118 and 55130), applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $234.10 **Benefit:** 75% = $175.60 85% = $199.00
Fee 55114	M-mode and two dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic or embolic disease or heart tumour, if: (a) the service involves all of the following: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques; (ii) real time colour flow mapping from at least 2 acoustic windows; (iii) recordings on video tape or digital media; and (b) the service is not associated with a service to which another item in this Subgroup (except items 55118 and 55130), applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $234.10 **Benefit:** 75% = $175.60 85% = $199.00
Fee 55115	M-mode and two dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of symptoms or signs of congenital heart disease, if: (a) the service involves all of the following: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques; (ii) real time colour flow mapping from at least 2 acoustic windows; (iii) recordings on video tape or digital media; and (b) the service is not associated with a service to which another item in this Subgroup (except items 55118 and 55130), applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $234.10 **Benefit:** 75% = $175.60 85% = $199.00
Fee 55116	Exercise stress echocardiography performed in conjunction with a service mentioned in item 11712, if: (a) the service involves all of the following: (i) two dimensional recordings before exercise (baseline) from at least 3 acoustic windows; (ii) matching recordings from the same windows at, or immediately after, peak exercise; (iii) recordings on digital media with equipment permitting display of baseline and matching peak images on the same screen; and (b) the service is not associated with a service to which another item in this Subgroup (except items 55118 and 55130), applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $265.55 **Benefit:** 75% = $199.20 85% = $225.75
Fee 55117	Pharmacological stress echocardiography performed in conjunction with a service mentioned in item 11712, if: (a) the service involves all of the following: (i) two dimensional recordings before drug infusion (baseline) from at least 3 acoustic windows; (ii) matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose; (iii) recordings on digital media with equipment permitting display of baseline and matching peak images on the same screen; and

	(b) the service is not associated with a service to which another item in this Subgroup (except items 55118 and 55130), applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $265.55 **Benefit:** 75% = $199.20 85% = $225.75
Fee 55118	Heart, two dimensional real time transoesophageal examination of, from at least 2 levels, and in more than one plane at each level, if: (a) the service includes: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on video tape or digital medium; and (b) the service is not an intra operative service (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $279.65 **Benefit:** 75% = $209.75 85% = $237.75
Fee 55130	Intra-operative two-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 being a service associated with a service to which item 55135 applies (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.55 **Benefit:** 75% = $129.45 85% = $146.70
Fee 55135	Intra-operative two-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 (replacement or repair) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure, not being a service associated with a service to which item 55130 applies (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.90 **Benefit:** 75% = $269.20 85% = $305.10

	Group I1. Ultrasound
	Subgroup 3. Vascular
Fee 55238	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with any of the following: (a) a service to which an item in Subgroup 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55244	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with any of the following: (a) a service to which item 55246 applies; (b) a service to which an item in Subgroup 4 applies; (c) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55246	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with any of the following: (a) a service to which item 55244 applies; (b) a service to which an item in Subgroup 4 applies; (c) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55248	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb or of arteries and bypass grafts in the upper limb, not being a service associated with any of the following: (a) a service to which an item in Subgroup 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55252	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with any of the following: (a) a service to which an item in Subgroup 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55274	Duplex scanning, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri orbital Doppler examination, not being a service associated with any of the following: (a) a service to which an item in Subgroup 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55276	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins or of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with any of the following: (a) a service to which an item in Subgroup 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55278	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels or of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service

	associated with any of the following: (a) a service to which an item in Subgroup 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55280	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra cranial vessels, not being a service associated with any of the following: (a) a service to which an item in Subgroup 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55282	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements: (a) by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent; and (b) performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence; and (c) if 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 performed, immediately before or for a period during the performance of the service; and (d) if the specialist or consultant physician interprets the results and prepares a report, not being a service associated with any of the following: (i) a service to which an item in Subgroup 4 applies; (ii) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55284	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements: (a) by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis; and (b) if indicated, assess the progress and management of: (i) priapism; or (ii) fibrosis of any type; or (iii) fracture of the tunica; or (iv) arteriovenous malformations; and (c) if 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 performed, immediately before or for a period during the performance of the service; and (d) if the specialist or consultant physician interprets the results and prepares a report, not being a service associated with any of the following: (i) a service to which an item in Subgroup 4 applies; (ii) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55292	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access grafts in the upper or lower limbs, not being a service associated with any of the

I1. ULTRASOUND	3. VASCULAR
	following: (a) a service to which an item in Subgroup 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55294	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins, or both, including any associated skin marking, for mapping of bypass conduit before vascular surgery, not being a service associated with any of the following: (a) a service to which an item in Subgroup 3 or 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $172.05 **Benefit:** 75% = $129.05 85% = $146.25
Fee 55296	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limbs below the inguinal ligament before varicose vein surgery, including any associated skin marking, not being a service associated with any of the following: (a) a service to which an item in Subgroup 3 or 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $112.70 **Benefit:** 75% = $84.55 85% = $95.80

I1. ULTRASOUND	4. UROLOGICAL
	Group I1. Ultrasound
	Subgroup 4. Urological
Fee 55600	Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in paragraph (c)) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient's current prostatic disease (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55603	Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner who made the assessment mentioned in paragraph (c) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and

I1. ULTRASOUND	4. UROLOGICAL
	(iv) recommended the scan for the management of the patient's current prostatic disease (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
I1. ULTRASOUND	**5. OBSTETRIC AND GYNAECOLOGICAL**
	Group I1. Ultrasound
	Subgroup 5. Obstetric And Gynaecological
Fee 55700	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, for determining the gestation, location, viability or number of foetuses, if the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $60.90 **Benefit:** 75% = $45.70 85% = $51.80 **Extended Medicare Safety Net Cap:** $32.95
Fee 55703	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, for determining the gestation, location, viability or number of foetuses, if the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.50 **Benefit:** 75% = $26.65 85% = $30.20 **Extended Medicare Safety Net Cap:** $16.55
Fee 55704	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, for determining the structure, gestation, location, viability

	or number of foetuses, if the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $71.05 **Benefit:** 75% = $53.30 85% = $60.40 **Extended Medicare Safety Net Cap:** $38.50
Fee 55705	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of foetuses, if the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.50 **Benefit:** 75% = $26.65 85% = $30.20 **Extended Medicare Safety Net Cap:** $16.55
Fee 55706	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, if: (a) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (b) the service is not performed in the same pregnancy as item 55709 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $101.50 **Benefit:** 75% = $76.15 85% = $86.30 **Extended Medicare Safety Net Cap:** $54.90
Fee 55707	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the pregnancy (as confirmed by ultrasound) is dated by a fetal crown rump length of 45 to 84 mm; and (b) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (c) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $71.05 **Benefit:** 75% = $53.30 85% = $60.40 **Extended Medicare Safety Net Cap:** $38.50
Fee 55708	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84 mm; and (b) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (c) the service is not performed with item 55700, 55703, 55704 or 55705, on the same patient within 24 hours (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.50 **Benefit:** 75% = $26.65 85% = $30.20 **Extended Medicare Safety Net Cap:** $16.55
Fee 55709	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, if: (a) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and

	(b the service is not performed in the same pregnancy as item 55706 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.55 **Benefit:** 75% = $28.95 85% = $32.80 **Extended Medicare Safety Net Cap:** $22.00
Fee 55712	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the service is requested by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) 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 (iv) has obstetric privileges at a non metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20 **Extended Medicare Safety Net Cap:** $65.90
Fee 55715	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (b) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.60 **Benefit:** 75% = $30.45 85% = $34.55 **Extended Medicare Safety Net Cap:** $22.00
Fee 55718	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the service is not performed in the same pregnancy as item 55723 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $101.50 **Benefit:** 75% = $76.15 85% = $86.30 **Extended Medicare Safety Net Cap:** $54.90
Fee 55721	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the service is requested by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) 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 (iv) has obstetric privileges at a non metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $116.70 **Benefit:** 75% = $87.55 85% = $99.20 **Extended Medicare Safety Net Cap:** $65.90
Fee 55723	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the service is not performed in the same pregnancy as item 55718 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.55 **Benefit:** 75% = $28.95 85% = $32.80 **Extended Medicare Safety Net Cap:** $22.00
Fee 55725	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.60 **Benefit:** 75% = $30.45 85% = $34.55 **Extended Medicare Safety Net Cap:** $22.00
Fee 55729	Duplex scanning, if: (a) the service involves: (i) B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery; and (ii) measured assessment of amniotic fluid volume after the 24th week of gestation; and (b) there is reason to suspect intrauterine growth retardation or a significant risk of fetal death; —examination and report (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $27.65 **Benefit:** 75% = $20.75 85% = $23.55 **Extended Medicare Safety Net Cap:** $16.55
Fee 55736	Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.90 **Benefit:** 75% = $96.70 85% = $109.60
Fee 55739	Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $57.85 **Benefit:** 75% = $43.40 85% = $49.20
Fee 55759	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, if: (a) ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (c) the service mentioned in item 55706, 55709, 55712, 55715 or 55762 is not performed in conjunction with the scan during the same pregnancy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $152.25 **Benefit:** 75% = $114.20 85% = $129.45
Fee	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy,

55762	ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (c) the service mentioned in item 55706, 55709, 55712, 55715 or 55759 is not performed in conjunction with the scan during the same pregnancy (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $60.90 **Benefit:** 75% = $45.70 85% = $51.80 **Extended Medicare Safety Net Cap:** $32.95
Fee 55764	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the service is requested by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (e) the service mentioned in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the scan during the same pregnancy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $162.40 **Benefit:** 75% = $121.80 85% = $138.05 **Extended Medicare Safety Net Cap:** $87.85
Fee 55766	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (d) the service mentioned in item 55706, 55709, 55712 or 55715, is not performed in conjunction with the scan during the same pregnancy (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $65.95 **Benefit:** 75% = $49.50 85% = $56.10 **Extended Medicare Safety Net Cap:** $32.95
Fee 55768	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (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 service is not performed in the same pregnancy as item 55770; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $152.25 **Benefit:** 75% = $114.20 85% = $129.45

I1. ULTRASOUND	5. OBSTETRIC AND GYNAECOLOGICAL
	Extended Medicare Safety Net Cap: $82.40
Fee 55770	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (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 service is not performed in the same pregnancy as item 55768; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $60.90 **Benefit:** 75% = $45.70 85% = $51.80 **Extended Medicare Safety Net Cap:** $32.95
Fee 55772	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the service is requested by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or (iv) 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 mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $162.40 **Benefit:** 75% = $121.80 85% = $138.05 **Extended Medicare Safety Net Cap:** $87.85
Fee 55774	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (c) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $65.95 **Benefit:** 75% = $49.50 85% = $56.10 **Extended Medicare Safety Net Cap:** $38.50

I1. ULTRASOUND	6. MUSCULOSKELETAL
	Group I1. Ultrasound
	Subgroup 6. Musculoskeletal
Fee 55812	Chest or abdominal wall, one or more areas, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55070, 55073, 55076 or 55079 (R) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55814	Chest or abdominal wall, one or more areas, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55070, 55073, 55076 or 55079 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55844	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, one or more areas, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $88.65 **Benefit:** 75% = $66.50 85% = $75.40
Fee 55846	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, one or more areas, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55848	Musculoskeletal ultrasound, 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 a service mentioned in item 55054 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $138.65 **Benefit:** 75% = $104.00 85% = $117.90
Fee 55850	Musculoskeletal ultrasound, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, if: (a) the medical practitioner or nurse practitioner has indicated on a request for a musculoskeletal ultrasound that an ultrasound guided intervention be performed if clinically indicated; and (b) the service is not performed in conjunction with a service mentioned in item 55054 or any other item in this Subgroup (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $183.05 **Benefit:** 75% = $137.30 85% = $155.60
Fee 55852	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55854	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55856	Hand or wrist or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55858 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55857	Hand or wrist, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55859 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55858	Hand or wrist, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55856 (R) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $122.90 **Benefit:** 75% = $92.20 85% = $104.50
Fee 55859	Hand or wrist, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55857 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
Fee 55860	Forearm or elbow, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55862 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55861	Forearm or elbow, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55863 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55862	Forearm or elbow, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55860 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 85% = $104.50
Fee 55863	Forearm or elbow, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55861 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
Fee 55864	Shoulder or upper arm, or both, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55866 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55865	Shoulder or upper arm, or both, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and

	(b) the service is not performed in conjunction with a service mentioned in item 55867 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55866	Shoulder or upper arm, or both, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55864 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 85% = $104.50
Fee 55867	Shoulder or upper arm, or both, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55865 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
Fee 55868	Hip or groin, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55870 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55869	Hip or groin, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55871 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55870	Hip or groin, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55868 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 85% = $104.50

Fee 55871	Hip or groin, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55869 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
Fee 55872	Paediatric hip examination for dysplasia, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55874 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55873	Paediatric hip examination for dysplasia, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55875 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55874	Paediatric hip examination for dysplasia, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55872 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 85% = $104.50
Fee 55875	Paediatric hip examination for dysplasia, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55873 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
Fee 55876	Buttock or thigh, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55878 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55877	Buttock or thigh or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55879 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55878	Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55876 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 85% = $104.50
Fee 55879	Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55877 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
Fee 55880	Knee, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass;

	(iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with item 55882 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55881	Knee, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with item 55883 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55882	Knee, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with a service mentioned in item 55880 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 85% = $104.50
Fee 55883	Knee, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with item 55881 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
Fee 55884	Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55886 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55885	Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55887 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55886	Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55884 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 85% = $104.50

I1. ULTRASOUND	6. MUSCULOSKELETAL
Fee 55887	Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55885 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
Fee 55888	Ankle or hind foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55890 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55889	Ankle or hind foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55891 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55890	Ankle or hind foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55888 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 85% = $104.50
Fee 55891	Ankle or hind foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55889 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
Fee 55892	Mid foot or fore foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55894 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
Fee 55893	Mid foot or fore foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55895 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
Fee 55894	Mid foot or fore foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55892 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 85% = $104.50
Fee 55895	Mid foot or fore foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55893 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
I2. COMPUTED TOMOGRAPHY	**1. HEAD**
	Group I2. Computed Tomography

I2. COMPUTED TOMOGRAPHY	1. HEAD
	Subgroup 1. Head
Fee 56001	Computed tomography—scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
Fee 56007	Computed tomography—scan of brain with intravenous contrast medium and with any scans of the brain before intravenous contrast injection, when performed, not being a service to which item 57007 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $253.75 **Benefit:** 75% = $190.35 85% = $215.70
Fee 56010	Computed tomography—scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when performed (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $255.90 **Benefit:** 75% = $191.95 85% = $217.55
Fee 56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $253.75 **Benefit:** 75% = $190.35 85% = $215.70
Fee 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) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $294.35 **Benefit:** 75% = $220.80 85% = $250.20
Fee 56022	Computed tomography—scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $228.35 **Benefit:** 75% = $171.30 85% = $194.10
Fee 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 before intravenous contrast injection, when performed (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $341.85 **Benefit:** 75% = $256.40 85% = $290.60
Fee 56030	Computed tomography—scan of facial bones, para nasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $228.35 **Benefit:** 75% = $171.30 85% = $194.10
Fee 56036	Computed tomography—scan of facial bones, para nasal sinuses or both, with scan of brain, with intravenous contrast medium, if: (a) a scan without intravenous contrast medium has been performed; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $341.85 **Benefit:** 75% = $256.40 85% = $290.60
I2. COMPUTED TOMOGRAPHY	**2. NECK**

I2. COMPUTED TOMOGRAPHY	2. NECK
	Group I2. Computed Tomography
	Subgroup 2. Neck
Fee 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) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $233.45 **Benefit:** 75% = $175.10 85% = $198.45
Fee 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) before intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $345.10 **Benefit:** 75% = $258.85 85% = $293.35

I2. COMPUTED TOMOGRAPHY	3. SPINE
	Group I2. Computed Tomography
	Subgroup 3. Spine
Fee 56219	Computed tomography—scan of spine, one 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 or 59275 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $331.10 **Benefit:** 75% = $248.35 85% = $281.45
Fee 56220	Computed tomography—scan of spine, cervical region, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $243.60 **Benefit:** 75% = $182.70 85% = $207.10
Fee 56221	Computed tomography—scan of spine, thoracic region, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $243.60 **Benefit:** 75% = $182.70 85% = $207.10
Fee 56223	Computed tomography—scan of spine, lumbosacral region, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $243.60 **Benefit:** 75% = $182.70 85% = $207.10
Fee 56224	Computed tomography—scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine before intravenous contrast injection when undertaken (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $356.65 **Benefit:** 75% = $267.50 85% = $303.20
Fee 56225	Computed tomography—scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine before intravenous contrast injection when undertaken (R) (Anaes.)

I2. COMPUTED TOMOGRAPHY	3. SPINE
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $356.65 **Benefit:** 75% = $267.50 85% = $303.20
Fee 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 (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $356.65 **Benefit:** 75% = $267.50 85% = $303.20
Fee 56233	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Computed tomography—scan of spine, 2 examinations of the kind referred to in items 56220, 56221 and 56223, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $243.60 **Benefit:** 75% = $182.70 85% = $207.10
Fee 56234	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Computed tomography—scan of spine, 2 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 before intravenous contrast injection when undertaken (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $356.65 **Benefit:** 75% = $267.50 85% = $303.20
Fee 56237	Computed tomography—scan of spine, 3 regions cervical, thoracic and lumbosacral, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $243.60 **Benefit:** 75% = $182.70 85% = $207.10
Fee 56238	Computed tomography—scan of spine, 3 regions, cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine before intravenous contrast injection when undertaken (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $356.65 **Benefit:** 75% = $267.50 85% = $303.20
I2. COMPUTED TOMOGRAPHY	**4. CHEST AND UPPER ABDOMEN**
	Group I2. Computed Tomography
	Subgroup 4. Chest and upper abdomen
Fee 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) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $299.40 **Benefit:** 75% = $224.55 85% = $254.50
Fee 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,

I2. COMPUTED TOMOGRAPHY	4. CHEST AND UPPER ABDOMEN
	including lungs, mediastinum, chest wall or pleura and upper abdomen before 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) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $406.00 **Benefit:** 75% = $304.50 85% = $345.10

I2. COMPUTED TOMOGRAPHY	5. UPPER ABDOMEN ONLY
	Group I2. Computed Tomography
	Subgroup 5. Upper abdomen only
Fee 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) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $253.75 **Benefit:** 75% = $190.35 85% = $215.70
Fee 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) before intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $365.40 **Benefit:** 75% = $274.05 85% = $310.60
Fee 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) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $253.75 **Benefit:** 75% = $190.35 85% = $215.70
Fee 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) before intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $365.40 **Benefit:** 75% = $274.05 85% = $310.60

I2. COMPUTED TOMOGRAPHY	6. UPPER ABDOMEN AND PELVIS
	Group I2. Computed Tomography
	Subgroup 6. Upper abdomen and pelvis
Fee 56501	Computed tomography—scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy and not being a service to which item 56801 or 57001 applies(R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $390.75 **Benefit:** 75% = $293.10 85% = $332.15
Fee 56507	Computed tomography—scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis before intravenous contrast injection, when performed, not for the purposes of virtual colonoscopy and not being a service to which item 56807 or 57007 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $487.25 **Benefit:** 75% = $365.45 85% = $414.20
Fee 56553	Computed tomography—scan of colon for exclusion or diagnosis of colorectal neoplasia in a

	symptomatic or high risk patient if: (a) one or more of the following applies: (i) the patient has had an incomplete colonoscopy in the 3 months before the scan; (ii) there is a high grade colonic obstruction; (iii) the service is requested by a specialist or consultant physician who performs colonoscopies in the practice of the specialist's or consultant physician's speciality; and (b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies; and (c) the service has not been performed on the patient in the 36 months before the scan (R) (Anaes.) **Fee:** $527.80 **Benefit:** 75% = $395.85 85% = $448.65

	Group I2. Computed Tomography
	Subgroup 7. Extremities
Fee 56620	Computed tomography—scan of knee, without intravenous contrast medium, not being a service to which item 56622 or 56629 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $223.30 **Benefit:** 75% = $167.50 85% = $189.85
Fee 56622	Computed tomography—scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), without intravenous contrast medium, not being a service to which item 56620 applies (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $223.30 **Benefit:** 75% = $167.50 85% = $189.85
Fee 56623	Computed tomography—scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), with intravenous contrast medium and with any scans of the lower limb before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $339.65 **Benefit:** 75% = $254.75 85% = $288.75
Fee 56626	Computed tomography—scan of knee, with intravenous contrast medium and with any scans of the knee before intravenous contrast injection, when performed, not being a service to which items 56623 or 56630 apply (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $339.65 **Benefit:** 75% = $254.75 85% = $288.75
Fee 56627	Computed tomography—scan of upper limb, left or right or both, any one region, or more than one region, without intravenous contrast medium (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $223.30 **Benefit:** 75% = $167.50 85% = $189.85
Fee 56628	Computed tomography—scan of upper limb, left or right or both, any one region, or more than one region, with intravenous contrast medium and with any scans of the upper limb before intravenous contrast injection, when performed (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $339.65 **Benefit:** 75% = $254.75 85% = $288.75
Fee 56629	Computed tomography—scan of upper limb and lower limb, left or right or both, any one region (other than knee), or more than one region (which may include knee) without intravenous contrast medium not

I2. COMPUTED TOMOGRAPHY	7. EXTREMITIES
	being a service to which item 56620 applies (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $223.30 **Benefit:** 75% = $167.50 85% = $189.85
Fee 56630	Computed tomography—scan of upper limb and lower limb, left or right or both, any one region (other than knee), or more than one region (which may include knee) with intravenous contrast medium with any scans of the limbs before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $339.65 **Benefit:** 75% = $254.75 85% = $288.75

I2. COMPUTED TOMOGRAPHY	8. CHEST, ABDOMEN, PELVIS AND NECK
	Group I2. Computed Tomography
	Subgroup 8. Chest, abdomen, pelvis and neck
Fee 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) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $473.55 **Benefit:** 75% = $355.20 85% = $402.55
Fee 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 before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $568.40 **Benefit:** 75% = $426.30 85% = $483.70

I2. COMPUTED TOMOGRAPHY	9. BRAIN, CHEST AND UPPER ABDOMEN
	Group I2. Computed Tomography
	Subgroup 9. Brain, chest and upper abdomen
Fee 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) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65
Fee 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 before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $576.25 **Benefit:** 75% = $432.20 85% = $491.55

I2. COMPUTED TOMOGRAPHY	10. PELVIMETRY
	Group I2. Computed Tomography
	Subgroup 10. Pelvimetry

I2. COMPUTED TOMOGRAPHY	10. PELVIMETRY
Fee 57201	Computed tomography—pelvimetry (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $157.55 **Benefit:** 75% = $118.20 85% = $133.95
I2. COMPUTED TOMOGRAPHY	**11. INTERVENTIONAL TECHNIQUES**
	Group I2. Computed Tomography
	Subgroup 11. Interventional techniques
Fee 57341	Computed tomography, in conjunction with a surgical procedure using interventional techniques (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $477.05 **Benefit:** 75% = $357.80 85% = $405.50
I2. COMPUTED TOMOGRAPHY	**12. SPIRAL ANGIOGRAPHY**
	Group I2. Computed Tomography
	Subgroup 12. Spiral angiography
Amend **Fee** 57351	Computed tomography—angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection—one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (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) a service to which item 57352, 57353 or 57354 applies has 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) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $517.65 **Benefit:** 75% = $388.25 85% = $440.05
Fee 57352	Computed tomography—angiography with intravenous contrast medium of any or all, or any part, of: (a) the arch of the aorta; or (b) the carotid arteries; or (c) the vertebral arteries and their branches (head and neck); including any scans performed before intravenous contrast injection—one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (d) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a general practitioner and the request indicates that the patient's case has

	been discussed with a specialist or consultant physician; and (e) the service is not a service to which another item in this group applies; and (f) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (g) the service is not a study performed to image the coronary arteries (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $517.65 **Benefit:** 75% = $388.25 85% = $440.05
Fee 57353	Computed tomography—angiography with intravenous contrast medium of any or all, or any part, of: (a) the ascending and descending aorta; or (b) the common iliac and abdominal branches including upper limbs (chest, abdomen and upper limbs); including any scans performed before intravenous contrast injection—one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (c) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a general practitioner and the request indicates that the patient's case has been discussed with a specialist or consultant physician; and (d) the service is not a service to which another item in this group applies; and (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (f) the service is not a study performed to image the coronary arteries (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $517.65 **Benefit:** 75% = $388.25 85% = $440.05
Fee 57354	Computed tomography—angiography with intravenous contrast medium of any or all, or any part, of: (a) the descending aorta; or (b) the pelvic vessels (aorto-iliac segment) and lower limbs; including any scans performed before intravenous contrast injection—one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (c) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a general practitioner and the request indicates that the patient's case has been discussed with a specialist or consultant physician; and (d) the service is not a service to which another item in this group applies; and (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and

I2. COMPUTED TOMOGRAPHY	12. SPIRAL ANGIOGRAPHY
	(f) the service is not a study performed to image the coronary arteries (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $517.65 **Benefit:** 75% = $388.25 85% = $440.05
Fee 57360	Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner if: (a) the request is made by a specialist or consultant physician; and (b) one of the following subparagraphs applies to the patient: (i) the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; (ii) the patient requires exclusion of coronary artery anomaly or fistula; (iii) the patient will be undergoing non coronary cardiac surgery (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $710.50 **Benefit:** 75% = $532.90 85% = $625.80

I2. COMPUTED TOMOGRAPHY	13. CONE BEAM COMPUTED TOMOGRAPHY
	Group I2. Computed Tomography
	Subgroup 13. Cone beam computed tomography
Fee 57362	Cone beam computed tomography—dental and temporo mandibular joint imaging (without contrast medium) for diagnosis and management of any of the following: (a) mandibular and dento alveolar fractures; (b) dental implant planning; (c) orthodontics; (d) endodontic conditions; (e) periodontal conditions; (f) temporo mandibular joint conditions Applicable once per patient per day, not being for a service to which any of items 57960 to 57969 apply, and not being a service associated with another service in Group I2 (R) (Anaes.) **Fee:** $114.85 **Benefit:** 75% = $86.15 85% = $97.65

I3. DIAGNOSTIC RADIOLOGY	1. RADIOGRAPHIC EXAMINATION OF EXTREMITIES
	Group I3. Diagnostic Radiology
	Subgroup 1. Radiographic Examination Of Extremities
Fee 57506	Hand, wrist, forearm, elbow or humerus (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $30.20 **Benefit:** 75% = $22.65 85% = $25.70
Fee 57509	Hand, wrist, forearm, elbow or humerus (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.35 **Benefit:** 75% = $30.30 85% = $34.30
Fee 57512	Hand and wrist, or hand, wrist and forearm, or forearm and elbow, or elbow and humerus (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $41.10 **Benefit:** 75% = $30.85 85% = $34.95
Fee 57515	Hand and wrist, or hand, wrist and forearm, or forearm and elbow, or elbow and humerus (R) (See para IN.0.19 of explanatory notes to this Category)

I3. DIAGNOSTIC RADIOLOGY	1. RADIOGRAPHIC EXAMINATION OF EXTREMITIES
	Fee: $54.80 **Benefit:** 75% = $41.10 85% = $46.60
Fee 57518	Foot, ankle, leg or femur (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
Fee 57521	Foot, ankle, leg or femur (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
Fee 57522	Knee (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
Fee 57523	Knee (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
Fee 57524	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $50.15 **Benefit:** 75% = $37.65 85% = $42.65
Fee 57527	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $66.75 **Benefit:** 75% = $50.10 85% = $56.75

I3. DIAGNOSTIC RADIOLOGY	2. RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS
	Group I3. Diagnostic Radiology
	Subgroup 2. Radiographic Examination Of Shoulder Or Pelvis
Fee 57700	Shoulder or scapula (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $41.10 **Benefit:** 75% = $30.85 85% = $34.95
Fee 57703	Shoulder or scapula (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.80 **Benefit:** 75% = $41.10 85% = $46.60
Fee 57706	Clavicle (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
Fee 57709	Clavicle (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
Fee 57712	Hip joint (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.85 **Benefit:** 75% = $35.90 85% = $40.70
Fee 57715	Pelvic girdle (R)

I3. DIAGNOSTIC RADIOLOGY	2. RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $61.80 **Benefit:** 75% = $46.35 85% = $52.55
Fee 57721	Femur, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $100.75 **Benefit:** 75% = $75.60 85% = $85.65

I3. DIAGNOSTIC RADIOLOGY	3. RADIOGRAPHIC EXAMINATION OF HEAD
	Group I3. Diagnostic Radiology
	Subgroup 3. Radiographic Examination Of Head
Fee 57901	Skull, not in association with item 57902 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $65.45 **Benefit:** 75% = $49.10 85% = $55.65
Fee 57902	Cephalometry, not in association with item 57901 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $65.45 **Benefit:** 75% = $49.10 85% = $55.65
Fee 57905	Mastoids or petrous temporal bones (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $65.45 **Benefit:** 75% = $49.10 85% = $55.65
Fee 57907	Sinuses or facial bones – orbit, maxilla or malar, any or all (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.00 **Benefit:** 75% = $36.00 85% = $40.80
Fee 57915	Mandible, not by orthopantomography technique (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.85 **Benefit:** 75% = $35.90 85% = $40.70
Fee 57918	Salivary calculus (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.85 **Benefit:** 75% = $35.90 85% = $40.70
Fee 57921	Nose (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.85 **Benefit:** 75% = $35.90 85% = $40.70
Fee 57924	Eye (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.85 **Benefit:** 75% = $35.90 85% = $40.70
Fee 57927	Temporo mandibular joints (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $50.40 **Benefit:** 75% = $37.80 85% = $42.85

I3. DIAGNOSTIC RADIOLOGY	3. RADIOGRAPHIC EXAMINATION OF HEAD
Fee 57930	Teeth—single area (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $33.40 **Benefit:** 75% = $25.05 85% = $28.40
Fee 57933	Teeth - full mouth (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $79.40 **Benefit:** 75% = $59.55 85% = $67.50
Fee 57939	Palato pharyngeal studies with fluoroscopic screening (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $65.45 **Benefit:** 75% = $49.10 85% = $55.65
Fee 57942	Palato pharyngeal studies without fluoroscopic screening (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $50.40 **Benefit:** 75% = $37.80 85% = $42.85
Fee 57945	Larynx, lateral airways and soft tissues of the neck, not being a service associated with a service to which item 57939 or 57942 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
Fee 57960	Orthopantomography for diagnosis or management (or both) of trauma, infection, tumour or a congenital or surgical condition of the teeth or maxillofacial region (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.10 **Benefit:** 75% = $36.10 85% = $40.90
Fee 57963	Orthopantomography for diagnosis or management (or both) of any of the following conditions, if the signs and symptoms of the condition is present: (a) impacted teeth; (b) caries; (c) periodontal pathology; (d) periapical pathology (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.10 **Benefit:** 75% = $36.10 85% = $40.90
Fee 57966	Orthopantomography for diagnosis or management (or both) of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.10 **Benefit:** 75% = $36.10 85% = $40.90
Fee 57969	Orthopantomography for diagnosis or management (or both) of temporo mandibular joint arthroses or dysfunction (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.10 **Benefit:** 75% = $36.10 85% = $40.90

I3. DIAGNOSTIC RADIOLOGY	4. RADIOGRAPHIC EXAMINATION OF SPINE
	Group I3. Diagnostic Radiology
	Subgroup 4. Radiographic Examination Of Spine
Fee 58100	Spine—cervical (R) (See para IN.0.19 of explanatory notes to this Category)

I3. DIAGNOSTIC RADIOLOGY	4. RADIOGRAPHIC EXAMINATION OF SPINE
	Fee: $68.15 **Benefit:** 75% = $51.15 85% = $57.95
Fee 58103	Spine—thoracic (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.95 **Benefit:** 75% = $42.00 85% = $47.60
Fee 58106	Spine—lumbosacral (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $78.15 **Benefit:** 75% = $58.65 85% = $66.45
Fee 58108	Spine—4 regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $111.65 **Benefit:** 75% = $83.75 85% = $94.95
Fee 58109	Spine—sacrococcygeal (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.70 **Benefit:** 75% = $35.80 85% = $40.55
Fee 58112	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Spine—2 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $98.70 **Benefit:** 75% = $74.05 85% = $83.90
Fee 58115	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Spine—3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $111.65 **Benefit:** 75% = $83.75 85% = $94.95
Fee 58120	Spine—4 regions, cervical, thoracic, lumbosacral and sacrococcygeal, if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year (R) **Fee:** $111.65 **Benefit:** 75% = $83.75 85% = $94.95
Fee 58121	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Spine—3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109, if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year (R) **Fee:** $111.65 **Benefit:** 75% = $83.75 85% = $94.95
I3. DIAGNOSTIC RADIOLOGY	**5. BONE AGE STUDY AND SKELETAL SURVEYS**
	Group I3. Diagnostic Radiology
	Subgroup 5. Bone Age Study And Skeletal Surveys

I3. DIAGNOSTIC RADIOLOGY	5. BONE AGE STUDY AND SKELETAL SURVEYS
Fee 58300	Bone age study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.70 **Benefit:** 75% = $30.55 85% = $34.60
Fee 58306	Skeletal survey (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $90.75 **Benefit:** 75% = $68.10 85% = $77.15

I3. DIAGNOSTIC RADIOLOGY	6. RADIOGRAPHIC EXAMINATION OF THORACIC REGION
	Group I3. Diagnostic Radiology
	Subgroup 6. Radiographic Examination Of Thoracic Region
Fee 58500	Chest (lung fields) by direct radiography (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.90 **Benefit:** 75% = $26.95 85% = $30.55
Fee 58503	Chest (lung fields) by direct radiography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.85 **Benefit:** 75% = $35.90 85% = $40.70
Fee 58506	Chest (lung fields) by direct radiography with fluoroscopic screening (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $61.65 **Benefit:** 75% = $46.25 85% = $52.45
Fee 58509	Thoracic inlet or trachea (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.35 **Benefit:** 75% = $30.30 85% = $34.30
Fee 58521	Left ribs, right ribs or sternum (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
Fee 58524	Left and right ribs, left ribs and sternum, or right ribs and sternum (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $57.35 **Benefit:** 75% = $43.05 85% = $48.75
Fee 58527	Left ribs, right ribs and sternum (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $70.45 **Benefit:** 75% = $52.85 85% = $59.90

I3. DIAGNOSTIC RADIOLOGY	7. RADIOGRAPHIC EXAMINATION OF URINARY TRACT
	Group I3. Diagnostic Radiology
	Subgroup 7. Radiographic Examination Of Urinary Tract
Fee 58700	Plain renal only (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $46.75 **Benefit:** 75% = $35.10 85% = $39.75

I3. DIAGNOSTIC RADIOLOGY	7. RADIOGRAPHIC EXAMINATION OF URINARY TRACT
Fee 58706	Intravenous pyelography, with or without preliminary plain films and with or without tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $160.25 **Benefit:** 75% = $120.20 85% = $136.25
Fee 58715	Antegrade or retrograde pyelography with or without preliminary plain films and with preparation and contrast injection, one side (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $153.80 **Benefit:** 75% = $115.35 85% = $130.75
Fee 58718	Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.00 **Benefit:** 75% = $96.00 85% = $108.80
Fee 58721	Retrograde micturating cysto urethrography, with preparation and contrast injection (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $140.30 **Benefit:** 75% = $105.25 85% = $119.30

I3. DIAGNOSTIC RADIOLOGY	8. RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM
	Group I3. Diagnostic Radiology
	Subgroup 8. Radiographic Examination Of Alimentary Tract And Biliary System
Fee 58900	Plain abdominal only, not being a service associated with a service to which item 58909, 58912 or 58915 applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $36.25 **Benefit:** 75% = $27.20 85% = $30.85
Fee 58903	Plain abdominal only, not being a service associated with a service to which item 58909, 58912 or 58915 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.30 **Benefit:** 75% = $36.25 85% = $41.10
Fee 58909	Barium or other opaque meal of one 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, 57942 or 57945 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $91.30 **Benefit:** 75% = $68.50 85% = $77.65
Fee 58912	Barium or other opaque meal of oesophagus, stomach, duodenum and follow through to colon, with or without screening of chest and with or without preliminary plain film (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $111.90 **Benefit:** 75% = $83.95 85% = $95.15
Fee 58915	Barium or other opaque meal, small bowel series only, with or without preliminary plain film (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $80.15 **Benefit:** 75% = $60.15 85% = $68.15
Fee 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.)

I3. DIAGNOSTIC RADIOLOGY	8. RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $140.60 **Benefit:** 75% = $105.45 85% = $119.55
Fee 58921	Opaque enema, with or without air contrast study and with or without preliminary plain films (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $137.30 **Benefit:** 75% = $103.00 85% = $116.75
Fee 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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $77.60 **Benefit:** 75% = $58.20 85% = $66.00
Fee 58933	Cholegraphy, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $208.70 **Benefit:** 75% = $156.55 85% = $177.40
Fee 58936	Cholegraphy, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $198.90 **Benefit:** 75% = $149.20 85% = $169.10
Fee 58939	Defaecogram (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $141.40 **Benefit:** 75% = $106.05 85% = $120.20

I3. DIAGNOSTIC RADIOLOGY	9. RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES
	Group I3. Diagnostic Radiology
	Subgroup 9. Radiographic Examination For Localisation Of Foreign Bodies
Fee 59103	Localisation of foreign body, if provided in conjunction with a service described in Subgroups 1 to 12 of Group I3 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $21.60 **Benefit:** 75% = $16.20 85% = $18.40

I3. DIAGNOSTIC RADIOLOGY	10. RADIOGRAPHIC EXAMINATION OF BREASTS
	Group I3. Diagnostic Radiology
	Subgroup 10. Radiographic Examination Of Breasts
Fee 59300	Mammography of both breasts if there is reason to suspect the presence of malignancy because of: (a) the past occurrence of breast malignancy in the patient; or (b) significant history of breast or ovarian malignancy in the patient's family; or (c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner (R) (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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $90.85 **Benefit:** 75% = $68.15 85% = $77.25
Fee 59302	Three dimensional tomosynthesis of both breasts, if there is reason to suspect the presence of malignancy because of: a) the past occurrence of breast malignancy in the patient; or b) significant history of breast or ovarian malignancy in the patient's family; or c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner Not being a service to which item 59300 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $205.05 **Benefit:** 75% = $153.80 85% = $174.30
Fee 59303	Mammography of one breast if: (a) the service is specifically requested 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 (ii) significant history of breast or ovarian malignancy in the patient's family; or (iii) symptoms or indications of breast disease found on examination of the patient by a medical practitioner (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.75 **Benefit:** 75% = $41.10 85% = $46.55
Fee 59305	Three dimensional tomosynthesis of one breast, if there is reason to suspect the presence of malignancy because of: a) the past occurrence of breast malignancy in the patient; or b) significant history of breast or ovarian malignancy in the patient's family; or c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner Not being a service to which item 59303 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.70 **Benefit:** 75% = $86.80 85% = $98.35

I3. DIAGNOSTIC RADIOLOGY	10. RADIOGRAPHIC EXAMINATION OF BREASTS
Fee 59312	Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $88.30 **Benefit:** 75% = $66.25 85% = $75.10
Fee 59314	Radiographic examination of one breast, in conjunction with a surgical procedure using interventional techniques (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $53.30 **Benefit:** 75% = $40.00 85% = $45.35
Fee 59318	Radiographic examination of excised breast tissue to confirm satisfactory excision of one or more lesions in one breast or both following pre-operative localisation in conjunction with a service under item 31536 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.75 **Benefit:** 75% = $35.85 85% = $40.60

I3. DIAGNOSTIC RADIOLOGY	12. RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA
	Group I3. Diagnostic Radiology
	Subgroup 12. Radiographic Examination With Opaque Or Contrast Media
Fee 59700	Discography, each disc, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $98.00 **Benefit:** 75% = $73.50 85% = $83.30
Fee 59703	Dacryocystography, one side, with or without preliminary plain film and with preparation and contrast injection (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $77.05 **Benefit:** 75% = $57.80 85% = $65.50
Fee 59712	Hysterosalpingography, with or without preliminary plain films and with preparation and contrast injection (R)(Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.40 **Benefit:** 75% = $86.55 85% = $98.10
Fee 59715	Bronchography, one side, with or without preliminary plain films and with preparation and contrast injection, on a person under 16 years of age (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $145.70 **Benefit:** 75% = $109.30 85% = $123.85
Fee 59718	Phlebography, one side, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $136.65 **Benefit:** 75% = $102.50 85% = $116.20
Fee 59724	Myelography, one 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.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $229.85 **Benefit:** 75% = $172.40 85% = $195.40

I3. DIAGNOSTIC RADIOLOGY	12. RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA
Fee 59733	Sialography, one side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.30 **Benefit:** 75% = $82.00 85% = $92.95
Fee 59739	Sinogram or fistulogram, one or more regions, with or without preliminary plain films and with preparation and contrast injection (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65
Fee 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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
Fee 59754	Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $222.65 **Benefit:** 75% = $167.00 85% = $189.30
Fee 59763	Air insufflation during video—fluoroscopic imaging including associated consultation (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $135.90 **Benefit:** 75% = $101.95 85% = $115.55

I3. DIAGNOSTIC RADIOLOGY	13. ANGIOGRAPHY
	Group I3. Diagnostic Radiology
	Subgroup 13. Angiography
Fee 59903	Angiocardiography, including the service mentioned in item 59970 or 61109, not being a service to which item 59912 or 59925 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $116.25 **Benefit:** 75% = $87.20 85% = $98.85
Fee 59912	Selective coronary arteriography, including the service mentioned in item 59970 or 61109, not being a service to which item 59903 or 59925 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $309.80 **Benefit:** 75% = $232.35 85% = $263.35
Fee 59925	Selective coronary arteriography and angiocardiography, including a service mentioned in item 59903, 59912, 59970 or 61109 (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $367.90 **Benefit:** 75% = $275.95 85% = $312.75
Fee 59970	Angiography or digital subtraction angiography, or both, with fluoroscopy and image acquisition, using a mobile image intensifier, including any preliminary plain films, preparation and contrast injection—one or more regions (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $170.80 **Benefit:** 75% = $128.10 85% = $145.20
Fee 60000	Digital subtraction angiography, examination of head and neck with or without arch aortography—1 to 3 data acquisition runs (R) (Anaes.)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $572.45 **Benefit:** 75% = $429.35 85% = $487.75
Fee 60003	Digital subtraction angiography, examination of head and neck with or without arch aortography—4 to 6 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $839.50 **Benefit:** 75% = $629.65 85% = $754.80
Fee 60006	Digital subtraction angiography, examination of head and neck with or without arch aortography—7 to 9 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,193.75 **Benefit:** 75% = $895.35 85% = $1109.05
Fee 60009	Digital subtraction angiography, examination of head and neck with or without arch aortography—10 or more data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,396.95 **Benefit:** 75% = $1047.75 85% = $1312.25
Fee 60012	Digital subtraction angiography, examination of thorax—1 to 3 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $572.45 **Benefit:** 75% = $429.35 85% = $487.75
Fee 60015	Digital subtraction angiography, examination of thorax—4 to 6 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $839.50 **Benefit:** 75% = $629.65 85% = $754.80
Fee 60018	Digital subtraction angiography, examination of thorax—7 to 9 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,193.75 **Benefit:** 75% = $895.35 85% = $1109.05
Fee 60021	Digital subtraction angiography, examination of thorax—10 or more data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,396.95 **Benefit:** 75% = $1047.75 85% = $1312.25
Fee 60024	Digital subtraction angiography, examination of abdomen—1 to 3 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $572.45 **Benefit:** 75% = $429.35 85% = $487.75
Fee 60027	Digital subtraction angiography, examination of abdomen—4 to 6 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $839.50 **Benefit:** 75% = $629.65 85% = $754.80
Fee 60030	Digital subtraction angiography, examination of abdomen—7 to 9 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,193.75 **Benefit:** 75% = $895.35 85% = $1109.05
Fee 60033	Digital subtraction angiography, examination of abdomen—10 or more data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,396.95 **Benefit:** 75% = $1047.75 85% = $1312.25
Fee 60036	Digital subtraction angiography, examination of upper limb or limbs—1 to 3 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $572.45 **Benefit:** 75% = $429.35 85% = $487.75
Fee 60039	Digital subtraction angiography, examination of upper limb or limbs—4 to 6 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $839.50 **Benefit:** 75% = $629.65 85% = $754.80
Fee 60042	Digital subtraction angiography, examination of upper limb or limbs—7 to 9 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,193.75 **Benefit:** 75% = $895.35 85% = $1109.05
Fee 60045	Digital subtraction angiography, examination of upper limb or limbs—10 or more data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,396.95 **Benefit:** 75% = $1047.75 85% = $1312.25
Fee 60048	Digital subtraction angiography, examination of lower limb or limbs—1 to 3 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $572.45 **Benefit:** 75% = $429.35 85% = $487.75
Fee 60051	Digital subtraction angiography, examination of lower limb or limbs—4 to 6 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $839.50 **Benefit:** 75% = $629.65 85% = $754.80
Fee 60054	Digital subtraction angiography, examination of lower limb or limbs—7 to 9 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,193.75 **Benefit:** 75% = $895.35 85% = $1109.05
Fee 60057	Digital subtraction angiography, examination of lower limb or limbs—10 or more data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,396.95 **Benefit:** 75% = $1047.75 85% = $1312.25
Fee 60060	Digital subtraction angiography, examination of aorta and lower limb or limbs—1 to 3 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $572.45 **Benefit:** 75% = $429.35 85% = $487.75
Fee 60063	Digital subtraction angiography, examination of aorta and lower limb or limbs—4 to 6 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $839.50 **Benefit:** 75% = $629.65 85% = $754.80
Fee 60066	Digital subtraction angiography, examination of aorta and lower limb or limbs—7 to 9 data acquisition runs (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,193.75 **Benefit:** 75% = $895.35 85% = $1109.05
Fee 60069	Digital subtraction angiography, examination of aorta and lower limb or limbs—10 or more data acquisition runs (R) (Anaes.)

I3. DIAGNOSTIC RADIOLOGY	13. ANGIOGRAPHY
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,396.95 **Benefit:** 75% = $1047.75 85% = $1312.25
Fee 60072	Selective arteriography or selective venography by digital subtraction angiography technique—one vessel (NR) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.80 **Benefit:** 75% = $36.60 85% = $41.50
Fee 60075	Selective arteriography or selective venography by digital subtraction angiography technique—2 vessels (NR) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $97.55 **Benefit:** 75% = $73.20 85% = $82.95
Fee 60078	Selective arteriography or selective venography by digital subtraction angiography technique—3 or more vessels (NR) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $146.40 **Benefit:** 75% = $109.80 85% = $124.45

I3. DIAGNOSTIC RADIOLOGY	15. FLUOROSCOPIC EXAMINATION
	Group I3. Diagnostic Radiology
	Subgroup 15. Fluoroscopic Examination
Fee 60500	Fluoroscopy, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
Fee 60503	Fluoroscopy, without general anaesthesia (not being a service associated with a radiographic examination) (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $30.20 **Benefit:** 75% = $22.65 85% = $25.70
Fee 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 Group applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $64.70 **Benefit:** 75% = $48.55 85% = $55.00
Fee 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 Group applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $100.40 **Benefit:** 75% = $75.30 85% = $85.35

I3. DIAGNOSTIC RADIOLOGY	16. PREPARATION FOR RADIOLOGICAL PROCEDURE
	Group I3. Diagnostic Radiology
	Subgroup 16. Preparation For Radiological Procedure
Fee 60918	Arteriography (peripheral) or phlebography—one vessel, when used in association with a service to which item 59903, 59912, 59925 or 59970 applies, not being a service associated with a service to which

I3. DIAGNOSTIC RADIOLOGY	16. PREPARATION FOR RADIOLOGICAL PROCEDURE
	any of items 60000 to 60078 apply (NR) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.85 **Benefit:** 75% = $35.90 85% = $40.70
Fee 60927	Selective arteriogram or phlebogram, when used in association with a service to which item 59903, 59912, 59925 or 59970 applies, not being a service associated with a service to which any of items 60000 to 60078 apply (NR) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.60 **Benefit:** 75% = $28.95 85% = $32.85

I3. DIAGNOSTIC RADIOLOGY	17. INTERVENTIONAL TECHNIQUES
	Group I3. Diagnostic Radiology
	Subgroup 17. Interventional Techniques
Fee 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 Group applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $262.80 **Benefit:** 75% = $197.10 85% = $223.40

I3. DIAGNOSTIC RADIOLOGY	18. MISCELLANEOUS
	Group I3. Diagnostic Radiology
	Subgroup 18. Miscellaneous
Fee 57541	Fee for a service rendered using first eligible x-ray procedure carried out during attendance at residential aged care facility, where the service has been requested by a medical practitioner who has attended the patient in person and the request identifies one or more of the following indications: a. the patient has experienced a fall and one or more of the following items apply to the service 57509, 57515, 57521, 57527, 57530, 57533, 57539, 57703, 57705, 57709, 57711, 57712, 57714, 57715, 57717, 58521, 58523, 58524, 58526, 58527, 58529, 57536; or b. pneumonia or heart failure is suspected and item 58503 or 58505 applies to the service; or c. acute abdomen or bowel obstruction is suspected and item 58903 or 58905 applies to the service. This call-out fee can be claimed once only per visit at a residential aged care facility irrespective of the number of patients attended. NOTE: If the service is bulked billed 95% of the fee is payable. The multiple services rule does not apply to this item. (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $74.75 **Benefit:** 75% = $56.10 85% = $63.55

I4. NUCLEAR MEDICINE IMAGING	1. NUCLEAR MEDICINE - NON PET

	Group I4. Nuclear Medicine Imaging
	Subgroup 1. Nuclear medicine - non PET
61302	Single stress or rest myocardial perfusion study—planar imaging (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.85 **Benefit:** 75% = $336.65 85% = $381.55
61303	Single stress or rest myocardial perfusion study—with single photon emission tomography and with planar imaging when performed (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $565.30 **Benefit:** 75% = $424.00 85% = $480.60
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $709.70 **Benefit:** 75% = $532.30 85% = $625.00
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 performed (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $834.90 **Benefit:** 75% = $626.20 85% = $750.20
61310	Myocardial infarct avid study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $367.30 **Benefit:** 75% = $275.50 85% = $312.25
61311	Single stress or rest myocardial perfusion study—with PET (R) Item 61311 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the *Health Insurance (Section 3C Diagnostic Imaging - Nuclear Medicine Services) Amendment (No. 2) Determination 2019* on the Federal Register of Legislation for further information. **Fee:** $565.30 **Benefit:** 75% = $424.00 85% = $480.60
61313	Gated cardiac blood pool study, (equilibrium) (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $303.35 **Benefit:** 75% = $227.55 85% = $257.85
61314	Gated cardiac blood pool study, with or without intervention, and first pass blood flow or cardiac shunt study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $420.00 **Benefit:** 75% = $315.00 85% = $357.00
61328	Lung perfusion study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $227.65 **Benefit:** 75% = $170.75 85% = $193.55
61332	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 PET (R) Item 61332 was only available from 14 September 2019 until 20 December 2019, during a national

	shortage of technetium. See the *Health Insurance (Section 3C Diagnostic Imaging - Nuclear Medicine Services) Amendment (No. 2) Determination 2019* on the Federal Register of Legislation for further information. **Fee:** $834.90 **Benefit:** 75% = $626.20 85% = $750.20
61333	Lung perfusion study and lung ventilation study using galligas or 68Ga-MAA, with PET (R) Item 61333 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the *Health Insurance (Section 3C Diagnostic Imaging - Nuclear Medicine Services) Amendment (No. 2) Determination 2019* on the Federal Register of Legislation for further information. **Fee:** $443.35 **Benefit:** 75% = $332.55 85% = $376.85
61336	Cerebral perfusion study, with PET (R) Item 61336 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the *Health Insurance (Section 3C Diagnostic Imaging - Nuclear Medicine Services) Amendment (No. 2) Determination 2019* on the Federal Register of Legislation for further information. **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $520.35
61337	Bone study—whole body, with PET, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Item 61337 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the *Health Insurance (Section 3C Diagnostic Imaging - Nuclear Medicine Services) Amendment (No. 2) Determination 2019* on the Federal Register of Legislation for further information. **Fee:** $479.80 **Benefit:** 75% = $359.85 85% = $407.85
61340	Lung ventilation study using aerosol, technegas or xenon gas (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $253.00 **Benefit:** 75% = $189.75 85% = $215.05
61341	Bone study—whole body and PET, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Item 61341 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the *Health Insurance (Section 3C Diagnostic Imaging - Nuclear Medicine Services) Amendment (No. 2) Determination 2019* on the Federal Register of Legislation for further information. **Fee:** $600.70 **Benefit:** 75% = $450.55 85% = $516.00
61344	Computed tomography performed at the same time and covering the same body area as positron emission tomography covered by items 61311, 61332, 61333, 61336, 61337 and 61341, for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued (R) Item 61344 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the *Health Insurance (Section 3C Diagnostic Imaging - Nuclear Medicine Services) Amendment (No. 2) Determination 2019* on the Federal Register of Legislation for further information. **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00

61348	Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $443.35 **Benefit:** 75% = $332.55 85% = $376.85
61353	Liver and spleen study (colloid) (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.60 **Benefit:** 75% = $289.95 85% = $328.65
61356	Red blood cell spleen or liver study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $392.80 **Benefit:** 75% = $294.60 85% = $333.90
61360	Hepatobiliary study, including morphine administration or pre-treatment with a cholagogue when performed (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.35 **Benefit:** 75% = $302.55 85% = $342.85
61361	Hepatobiliary study with formal quantification following baseline imaging, using a cholagogue (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $461.40 **Benefit:** 75% = $346.05 85% = $392.20
61364	Bowel haemorrhage study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $496.95 **Benefit:** 75% = $372.75 85% = $422.45
61368	Meckel's diverticulum study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $223.10 **Benefit:** 75% = $167.35 85% = $189.65
61369	Indium-labelled octreotide study (including single photon emission tomography when undertaken), if: (a) a gastro-entero-pancreatic endocrine tumour is suspected on the basis of biochemical evidence with negative or equivocal conventional imaging; or (b) both: (i) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified on the basis of conventional techniques; and (ii) the study is to exclude additional disease sites (R) **Fee:** $2,015.75 **Benefit:** 75% = $1511.85 85% = $1931.05
61372	Salivary study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $223.10 **Benefit:** 75% = $167.35 85% = $189.65
61373	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when performed (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $489.70 **Benefit:** 75% = $367.30 85% = $416.25
61376	Oesophageal clearance study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $143.35 **Benefit:** 75% = $107.55 85% = $121.85
61381	Gastric emptying study, using single tracer (R) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $574.35 **Benefit:** 75% = $430.80 85% = $489.65
61383	Combined solid and liquid gastric emptying study using dual isotope technique or the same isotope on separate days (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $624.95 **Benefit:** 75% = $468.75 85% = $540.25
61384	Radionuclide colonic transit study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $687.70 **Benefit:** 75% = $515.80 85% = $603.00
61386	Renal study, including perfusion and renogram images and computer analysis or cortical study with planar imaging (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $332.50 **Benefit:** 75% = $249.40 85% = $282.65
61387	Renal cortical study, with single photon emission tomography and planar quantification (R) (See para IN.0.19 of explanatory notes to this Category) **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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $370.55 **Benefit:** 75% = $277.95 85% = $315.00
61390	Renal study with diuretic administration after a baseline study (R) (See para IN.0.19 of explanatory notes to this Category) **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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $605.50 **Benefit:** 75% = $454.15 85% = $520.80
61397	Cystoureterogram (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.85 **Benefit:** 75% = $185.15 85% = $209.85
61402	Cerebral perfusion study, with single photon emission tomography and with planar imaging when performed (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $520.35
61409	Cerebro spinal fluid transport study, with imaging on 2 or more separate occasions (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $873.50 **Benefit:** 75% = $655.15 85% = $788.80
61413	Cerebro spinal fluid shunt patency study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $225.95 **Benefit:** 75% = $169.50 85% = $192.10
61421	Bone study—whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $479.80 **Benefit:** 75% = $359.85 85% = $407.85
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $600.70 **Benefit:** 75% = $450.55 85% = $516.00
61426	Whole body study using iodine (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $554.80 **Benefit:** 75% = $416.10 85% = $471.60
61429	Whole body study using gallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $543.00 **Benefit:** 75% = $407.25 85% = $461.55
61430	Whole body study using gallium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $659.45 **Benefit:** 75% = $494.60 85% = $574.75
61433	Whole body study using cells labelled with technetium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $496.95 **Benefit:** 75% = $372.75 85% = $422.45
61434	Whole body study using cells labelled with technetium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $615.40 **Benefit:** 75% = $461.55 85% = $530.70
61438	Whole body study using thallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $672.95 **Benefit:** 75% = $504.75 85% = $588.25
61441	Bone marrow study—whole body using technetium labelled bone marrow agents (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $489.70 **Benefit:** 75% = $367.30 85% = $416.25
61442	Whole body study, using gallium—with single photon emission tomography of 2 or more body regions acquired separately (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $752.35 **Benefit:** 75% = $564.30 85% = $667.65
61445	Bone marrow study—localised using technetium labelled agent (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80
61446	Regional scintigraphic study, using an approved bone scanning agent, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging on a separate occasion (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $333.55 **Benefit:** 75% = $250.20 85% = $283.55
61449	Regional scintigraphic study, using an approved bone scanning agent and single photon emission tomography, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging

	on a separate occasion (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $456.20 **Benefit:** 75% = $342.15 85% = $387.80
61450	Localised study using gallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $397.55 **Benefit:** 75% = $298.20 85% = $337.95
61453	Localised study using gallium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $514.70 **Benefit:** 75% = $386.05 85% = $437.50
61454	Localised study using cells labelled with technetium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $348.10 **Benefit:** 75% = $261.10 85% = $295.90
61457	Localised study using cells labelled with technetium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $470.45 **Benefit:** 75% = $352.85 85% = $399.90
61461	Localised study using thallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $527.85 **Benefit:** 75% = $395.90 85% = $448.70
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 item 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469 or 61485, if there is no additional administration of radiopharmaceutical and if the previous radionuclide scan was abnormal or equivocal (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $129.00 **Benefit:** 75% = $96.75 85% = $109.65
61469	Lymphoscintigraphy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $348.10 **Benefit:** 75% = $261.10 85% = $295.90
61473	Thyroid study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $175.40 **Benefit:** 75% = $131.55 85% = $149.10
61480	Parathyroid study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.85 **Benefit:** 75% = $290.15 85% = $328.85
61485	Adrenal study, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $999.20 **Benefit:** 75% = $749.40 85% = $914.50

I4. NUCLEAR MEDICINE IMAGING	1. NUCLEAR MEDICINE - NON PET
	Tear duct study (R) (See para IN.0.19 of explanatory notes to this Category)
61495	**Fee:** $223.10 **Benefit:** 75% = $167.35 85% = $189.65
	Particle perfusion study (infra arterial) or Le Veen shunt study (R) (See para IN.0.19 of explanatory notes to this Category)
61499	**Fee:** $253.00 **Benefit:** 75% = $189.75 85% = $215.05
	CT scan performed at the same time and covering the same body area as single photon emission tomography or positron emission tomography for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued and only in association with items 61302 to 61647 (R) (See para IN.0.19 of explanatory notes to this Category)
61505	**Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
	LeukoScan study of the long bones and feet for suspected osteomyelitis, if: (a) the patient does not have access to ex vivo white blood cell scanning; and (b) the patient is not being investigated for other sites of infection (R) (See para IN.0.19 of explanatory notes to this Category)
61650	**Fee:** $878.70 **Benefit:** 75% = $659.05 85% = $794.00

I4. NUCLEAR MEDICINE IMAGING	2. PET
	Group I4. Nuclear Medicine Imaging
	Subgroup 2. PET
	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) (See para IN.0.19 of explanatory notes to this Category)
61523	**Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
	Whole body FDG PET study, performed for the staging of locally advanced (Stage III) breast cancer, for a patient who is considered suitable for active therapy (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
61524	**Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
	Whole body FDG PET study, performed for the evaluation of suspected metastatic or suspected locally or regionally recurrent breast carcinoma, for a patient who is considered suitable for active therapy (R) (Anaes.)
61525	

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61538	FDG PET study of the brain for evaluation of suspected residual or recurrent malignant brain tumour based on anatomical imaging findings, after definitive therapy (or during ongoing chemotherapy) in patients who are considered suitable for further active therapy. (R) **Fee:** $901.00 **Benefit:** 75% = $675.75 85% = $816.30
61541	Whole body FDG PET study, following initial therapy, for the evaluation of suspected residual, metastatic or recurrent colorectal carcinoma in patients considered suitable for active therapy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61553	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected metastatic or recurrent malignant melanoma in patients considered suitable for active therapy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $914.30
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $918.00 **Benefit:** 75% = $688.50 85% = $833.30
61565	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent ovarian carcinoma in patients considered suitable for active therapy. (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61571	Whole body FDG PET study, for the further primary staging of patients with histologically proven carcinoma of the uterine cervix, at FIGO stage IB2 or greater by conventional staging, prior to planned radical radiation therapy or combined modality therapy with curative intent. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61575	Whole body FDG PET study, for the further staging of patients with confirmed local recurrence of carcinoma of the uterine cervix considered suitable for salvage pelvic chemoradiotherapy or pelvic exenteration with curative intent. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61577	Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61598	Whole body FDG PET study performed for the staging of biopsy-proven newly diagnosed or recurrent head and neck cancer (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61604	Whole body FDG PET study performed for the evaluation of patients with suspected residual head and neck cancer after definitive treatment, and who are suitable for active therapy (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30

I4. NUCLEAR MEDICINE IMAGING	2. PET
61610	Whole body FDG PET study performed for the evaluation of metastatic squamous cell carcinoma of unknown primary site involving cervical nodes (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61620	Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61622	Whole body FDG PET study to assess response to first line therapy either during treatment or within three months of completing definitive first line treatment for Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61628	Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61632	Whole body FDG PET study to assess response to second-line chemotherapy if haemopoietic stem cell transplantation is being considered for Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61640	Whole body FDG PET study for initial staging of patients with biopsy-proven bone or soft tissue sarcoma (excluding gastrointestinal stromal tumour) considered by conventional staging to be potentially curable. (R) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $914.30
61646	Whole body FDG PET study for the evaluation of patients with suspected residual or recurrent sarcoma (excluding gastrointestinal stromal tumour) after the initial course of definitive therapy to determine suitability for subsequent therapy with curative intent. (R) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $914.30
61647	Whole body ^{68}Ga DOTA peptide PET study, if: (a) a gastro entero pancreatic neuroendocrine tumour is suspected on the basis of biochemical evidence with negative or equivocal conventional imaging; or (b) both: (i) a surgically amenable gastro entero pancreatic neuroendocrine tumour has been identified on the basis of conventional techniques; and (ii) the study is for excluding additional disease sites (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30

I5. MAGNETIC RESONANCE IMAGING	1. SCAN OF HEAD - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 1. Scan Of Head - For Specified Conditions
63001	MRI—scan of head (including MRA, if performed) for tumour of the brain or meninges (R) (Anaes.)

	(Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63004	MRI—scan of head (including MRA, if performed) for inflammation of brain or meninges (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63007	MRI—scan of head (including MRA, if performed) for skull base or orbital tumour (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63010	MRI—scan of head (including MRA, if performed) for stereotactic scan of brain, with fiducials in place, for the sole purpose of allowing planning for stereotactic neurosurgery (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60

	Group I5. Magnetic Resonance Imaging
	Subgroup 2. Scan Of Head - For Specified Conditions
63040	MRI—scan of head (including MRA, if performed) for acoustic neuroma (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
63043	MRI—scan of head (including MRA, if performed) for pituitary tumour (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63046	MRI—scan of head (including MRA, if performed) for toxic or metabolic or ischaemic encephalopathy (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63049	MRI—scan of head (including MRA, if performed) for demyelinating disease of the brain (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63052	MRI—scan of head (including MRA, if performed) for congenital malformation of the brain or meninges (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63055	MRI—scan of head (including MRA, if performed) for venous sinus thrombosis (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

I5. MAGNETIC RESONANCE IMAGING	2. SCAN OF HEAD - FOR SPECIFIED CONDITIONS
	Fee: $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63058	MRI—scan of head (including MRA, if performed) for head trauma (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63061	MRI—scan of head (including MRA, if performed) for epilepsy (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63064	MRI—scan of head (including MRA, if performed) for stroke (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63067	MRI—scan of head (including MRA, if performed) for carotid or vertebral artery dissection (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63070	MRI—scan of head (including MRA, if performed) for intracranial aneurysm (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63073	MRI—scan of head (including MRA, if performed) for intracranial arteriovenous malformation (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

I5. MAGNETIC RESONANCE IMAGING	3. SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 3. Scan Of Head And Neck Vessels - For Specified Conditions
63101	MRI and MRA of extracranial or intracranial circulation (or both)—scan of head and neck vessels for stroke (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90

I5. MAGNETIC RESONANCE IMAGING	4. SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 4. Scan Of Head And Cervical Spine - For Specified Conditions
63111	MRI—scan of head and cervical spine (including MRA, if performed) for tumour of the central nervous system or meninges (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63114	MRI—scan of head and cervical spine (including MRA, if performed) for inflammation of the central

I5. MAGNETIC RESONANCE IMAGING	4. SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS
	nervous system or meninges (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90

I5. MAGNETIC RESONANCE IMAGING	5. SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 5. Scan Of Head And Cervical Spine - For Specified Conditions
63125	MRI—scan of head and cervical spine (including MRA, if performed) for demyelinating disease of the central nervous system (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63128	MRI—scan of head and cervical spine (including MRA, if performed) for congenital malformation of the central nervous system or meninges (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63131	MRI—scan of head and cervical spine (including MRA, if performed) for syrinx (congenital or acquired) (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90

I5. MAGNETIC RESONANCE IMAGING	6. SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR INFECTION OR TUMOUR
	Group I5. Magnetic Resonance Imaging
	Subgroup 6. Scan Of Spine - One Region Or Two Contiguous Regions - For Infection or Tumour
63151	MRI—scan of one region or 2 contiguous regions of the spine for infection (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63154	MRI—scan of one region or 2 contiguous regions of the spine for tumour (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65

I5. MAGNETIC RESONANCE IMAGING	7. SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR OTHER CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 7. Scan Of Spine - One Region Or Two Contiguous Regions - For Other Conditions
63161	MRI—scan of one region or 2 contiguous regions of the spine for demyelinating disease (R) (Anaes.) (Contrast) (Anaes.)

I5. MAGNETIC RESONANCE IMAGING	7. SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR OTHER CONDITIONS
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63164	MRI—scan of one region or 2 contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63167	MRI—scan of one region or 2 contiguous regions of the spine for myelopathy (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63170	MRI—scan of one region or 2 contiguous regions of the spine for syrinx (congenital or acquired) (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63173	MRI—scan of one region or 2 contiguous regions of the spine for cervical radiculopathy (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63176	MRI—scan of one region or 2 contiguous regions of the spine for sciatica (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63179	MRI—scan of one region or 2 contiguous regions of the spine for spinal canal stenosis (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63182	MRI—scan of one region or 2 contiguous regions of the spine for previous spinal surgery (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63185	MRI—scan of one region or 2 contiguous regions of the spine for trauma (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65

I5. MAGNETIC RESONANCE IMAGING	8. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR INFECTION OR TUMOUR
	Group I5. Magnetic Resonance Imaging
	Subgroup 8. Scan Of Spine - Three Contiguous Regions Or Two Non-Contiguous Regions - For Infection or Tumour
63201	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for infection (R) (Anaes.) (Contrast) (Anaes.)

I5. MAGNETIC RESONANCE IMAGING	8. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR INFECTION OR TUMOUR
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63204	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for tumour (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80

I5. MAGNETIC RESONANCE IMAGING	9. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR OTHER CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 9. Scan Of Spine - Three Contiguous Regions Or Two Non-Contiguous Regions - For Other Conditions
63219	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for demyelinating disease (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63222	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63225	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for myelopathy (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63228	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for syrinx (congenital or acquired) (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63231	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for cervical radiculopathy (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63234	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for sciatica (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63237	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for spinal canal stenosis (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63240	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for previous spinal surgery (R)

I5. MAGNETIC RESONANCE IMAGING	9. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR OTHER CONDITIONS
	(Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63243	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for trauma (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80

I5. MAGNETIC RESONANCE IMAGING	10. SCAN OF CERVICAL SPINE AND BRACHIAL PLEXUS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 10. Scan Of Cervical Spine And Brachial Plexus - For Specified Conditions
63271	MRI—scan of cervical spine and brachial plexus for tumour (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63274	MRI—scan of cervical spine and brachial plexus for trauma (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63277	MRI—scan of cervical spine and brachial plexus for cervical radiculopathy (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63280	MRI—scan of cervical spine and brachial plexus for previous surgery (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90

I5. MAGNETIC RESONANCE IMAGING	11. SCAN OF MUSCULOSKELETAL SYSTEM - FOR TUMOUR, INFECTION OR OSTEONECROSIS
	Group I5. Magnetic Resonance Imaging
	Subgroup 11. Scan Of Musculoskeletal System - For Tumour, Infection or Osteonecrosis
63301	MRI—scan of musculoskeletal system for tumour arising in bone or musculoskeletal system, excluding tumours arising in breast, prostate or rectum (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63304	MRI—scan of musculoskeletal system for infection arising in bone or musculoskeletal system, excluding infection arising in breast, prostate or rectum (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63307	MRI—scan of musculoskeletal system for osteonecrosis (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70

I5. MAGNETIC RESONANCE IMAGING	12. SCAN OF MUSCULOSKELETAL SYSTEM - FOR JOINT DERANGEMENT
	Group I5. Magnetic Resonance Imaging
	Subgroup 12. Scan Of Musculoskeletal System - For Joint Derangement
63322	MRI—scan of musculoskeletal system for derangement of hip or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63325	MRI—scan of musculoskeletal system for derangement of shoulder or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63328	MRI—scan of musculoskeletal system for derangement of knee or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63331	MRI—scan of musculoskeletal system for derangement of ankle or foot (or both) or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63334	MRI—scan of musculoskeletal system for derangement of one or both temporomandibular joints or their supporting structures (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
63337	MRI—scan of musculoskeletal system for derangement of wrist or hand (or both) or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63340	MRI—scan of musculoskeletal system for derangement of elbow or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

I5. MAGNETIC RESONANCE IMAGING	13. SCAN OF MUSCULOSKELETAL SYSTEM - FOR GAUCHER DISEASE
	Group I5. Magnetic Resonance Imaging
	Subgroup 13. Scan Of Musculoskeletal System - For Gaucher Disease
63361	MRI—scan of musculoskeletal system for Gaucher disease (R) (Anaes.) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

I5. MAGNETIC RESONANCE IMAGING	14. SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging

I5. MAGNETIC RESONANCE IMAGING	14. SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	Subgroup 14. Scan Of Cardiovascular System - For Specified Conditions
63385	MRI—scan of cardiovascular system for congenital disease of the heart or a great vessel (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63388	MRI—scan of cardiovascular system for tumour of the heart or a great vessel (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63391	MRI—scan of cardiovascular system for abnormality of thoracic aorta (R) (Anaes.) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63395	MRI—scan of cardiovascular system for assessment of myocardial structure and function involving: (a) dedicated right ventricular views; and (b) 3D volumetric assessment of the right ventricle; and (c) reporting of end diastolic and end systolic volumes, ejection fraction and BSA indexed values; if the request for the scan indicates that: (d) the patient presented with symptoms consistent with arrhythmogenic right ventricular cardiomyopathy (ARVC); or (e) investigative findings in relation to the patient are consistent with ARVC (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $855.20 **Benefit:** 75% = $641.40 85% = $770.50
63397	MRI—scan of cardiovascular system for assessment of myocardial structure and function involving: (a) dedicated right ventricular views; and (b) 3D volumetric assessment of the right ventricle; and (c) reporting of end diastolic and end systolic volumes, ejection fraction and BSA indexed values; if the request for the scan indicates that the patient: (d) is asymptomatic; and (e) has one or more first degree relatives diagnosed with confirmed arrhythmogenic right ventricular cardiomyopathy (ARVC) (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $855.20 **Benefit:** 75% = $641.40 85% = $770.50

I5. MAGNETIC RESONANCE IMAGING	15. MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS

I5. MAGNETIC RESONANCE IMAGING	15. MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 15. Magnetic Resonance Angiography - Scan Of Cardiovascular System - For Specified Conditions
63401	MRA—if the request for the scan specifically identifies the clinical indication for the scan—scan of cardiovascular system for vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63404	MRA—if the request for the scan specifically identifies the clinical indication for the scan—scan of cardiovascular system for obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

I5. MAGNETIC RESONANCE IMAGING	16. MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	Group I5. Magnetic Resonance Imaging
	Subgroup 16. Magnetic Resonance Angiography - For Specified Conditions - Person Under The Age Of 16 Years
63416	MRA—scan of person under the age of 16 for the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

I5. MAGNETIC RESONANCE IMAGING	17. MAGNETIC RESONANCE IMAGING - PERSON UNDER THE AGE OF 16 YEARS - FOR PHYSEAL FUSION OR GAUCHER DISEASE
	Group I5. Magnetic Resonance Imaging
	Subgroup 17. Magnetic Resonance Imaging - Person Under the Age of 16 Years - For Physeal Fusion or Gaucher Disease
63425	MRI—scan of person under the age of 16 for post inflammatory or post traumatic physeal fusion (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63428	MRI—scan of person under the age of 16 for Gaucher disease (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

I5. MAGNETIC RESONANCE IMAGING	18. MAGNETIC RESONANCE IMAGING - PERSON UNDER THE AGE OF 16 YEARS - FOR OTHER CONDITIONS

I5. MAGNETIC RESONANCE IMAGING	18. MAGNETIC RESONANCE IMAGING - PERSON UNDER THE AGE OF 16 YEARS - FOR OTHER CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 18. Magnetic Resonance Imaging - Person Under The Age Of 16 Years - For Other Conditions
63440	MRI—scan of person under the age of 16 for pelvic or abdominal mass (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63443	MRI—scan of person under the age of 16 for mediastinal mass (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63446	MRI—scan of person under the age of 16 for congenital uterine or anorectal abnormality (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

I5. MAGNETIC RESONANCE IMAGING	19. SCAN OF BODY - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 19. Scan Of Body - For Specified Conditions
63454	MRI – scan of the pelvis or abdomen, if: (a) the pregnancy is at, or after, 18 weeks gestation; and (b) fetal central nervous system abnormality is suspected; and (c) an ultrasound has been performed and is provided by, or on behalf of, or at the request of, a specialist who is practising in the specialty of obstetrics; and (d) the diagnosis is indeterminate or requires further examination; and (e) the service is requested by a specialist practising in the specialty of obstetrics (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1115.30
63461	MRI—scan of the body for adrenal mass in a patient with a malignancy that is otherwise resectable (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63464	MRI—scan of both breasts for the detection of cancer, if a dedicated breast coil is used, the request for the scan identifies that the person is asymptomatic and is younger than 50 years of age, and the request for the scan identifies: (a) that the patient is at high risk of developing breast cancer, due to one of the following: (i) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (ii) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or

	ovarian cancer, if any of the relatives has been diagnosed with bilateral breast cancer, had onset of breast cancer before the age of 40 years, had onset of ovarian cancer before the age of 50 years, has been diagnosed with breast and ovarian cancer (at the same time or at different times), has Ashkenazi Jewish ancestry or is a male relative who has been diagnosed with breast cancer; (iii) one first or second degree relative diagnosed with breast cancer at age 45 years or younger, and another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or (b) that genetic testing has identified the presence of a high risk breast cancer gene mutation (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30
63467	MRI—scan of both breasts for the detection of cancer, if: (a) a dedicated breast coil is used; and (b) the person has had an abnormality detected as a result of a service mentioned in item 63464 performed in the previous 12 months (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30
63487	MRI—scan of both breasts, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that: (i) the patient has been diagnosed with metastatic cancer restricted to the regional lymph nodes; and (ii) clinical examination and conventional imaging have failed to identify the primary cancer (R) (Anaes.) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30
63489	MRI—guided biopsy, if: (a) the request for the scan identifies that the patient has a suspicious lesion seen on MRI but not on conventional imaging; and (b) an ultrasound scan of the affected breast, performed immediately before the biopsy, confirms that the lesion is not amenable to biopsy guided by conventional imaging; and (c) a dedicated breast coil is used (R) (Anaes.) **Fee:** $1,440.00 **Benefit:** 75% = $1080.00 85% = $1355.30
63531	MRI—scan of both breasts, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that: (i) the patient has a breast lesion; and (ii) the results of conventional imaging are inconclusive for the presence of breast cancer; and (iii) biopsy has not been possible (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30

63533	MRI—scan of both breasts, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that: (i) the patient has been diagnosed with a breast cancer; and (ii) there is a discrepancy between the clinical assessment and the conventional imaging assessment of the extent of the malignancy; and (c) the results of breast MRI imaging may alter treatment planning (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30
Amend 63541	Multiparametric Magnetic Resonance Imaging scan of the prostate for the detection of cancer, if the patient is referred by an urologist, radiation oncologist, or medical oncologist and the request for the scan identifies: that the patient is suspected of developing prostate cancer, due to one of the following: (i) a digital rectal examination which is suspicious for prostate cancer; or (ii) in a person under 70 years, at least two prostate specific antigen (PSA) tests performed within an interval of 1- 3 months are greater than 3.0 ng/ml, and the free/total PSA ratio is less than 25% or the repeat PSA exceeds 5.5 ng/ml; or (iii) in a person under 70 years, whose risk of developing prostate cancer based on relevant family history is at least double the average risk, at least two PSA tests performed within an interval of 1- 3 months are greater than 2.0 ng/ml, and the free/total PSA ratio is less than 25%; or (iv) in a person 70 years or older, at least two PSA tests performed within an interval of 1- 3 months are greater than 5.5ng/ml and the free/total PSA ratio is less than 25%. using a standardised image acquisition protocol involving T2 Weighted Imaging, Diffusion Weighted Imaging, and Dynamic Contrast Enhancement (unless contraindicated) (R) Note: Benefits are payable on one occasion only in any 12 month period. Relevant family history is a first degree relative with prostate cancer, or suspected of carrying a BRCA 1 or BRCA 2 mutation. (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $382.50
Amend 63543	Multiparametric Magnetic Resonance Imaging scan of the prostate for the assessment of cancer, if the patient is referred by an urologist, radiation oncologist, or medical oncologist and: the request for the scan identifies: (i) the patient is under active surveillance following a confirmed diagnosis of prostate cancer by biopsy histopathology; and (ii) the patient is not planning or undergoing treatment for prostate cancer. using a standardised image acquisition protocol involving T2 Weighted Imaging, Diffusion Weighted

I5. MAGNETIC RESONANCE IMAGING	19. SCAN OF BODY - FOR SPECIFIED CONDITIONS
	Imaging, and Dynamic Contrast Enhancement (unless contraindicated) (R) Note: Benefits are payable at the time of diagnosis of prostate cancer, 12 months following diagnosis and then every 3rd year thereafter or at any time, if there is a clinical concern, including PSA progression. This item is not to be used for the purposes of treatment planning or for monitoring after treatment. (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $382.50
63547	MRI—scan of both breasts for the detection of cancer, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that: (i) the patient has a breast implant in situ; and (ii) anaplastic large cell lymphoma has been diagnosed (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30

I5. MAGNETIC RESONANCE IMAGING	20. SCANS OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 20. Scans Of Pelvis And Upper Abdomen - For Specified Conditions
63470	MRI—scan of the pelvis for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater, if the request for scan identifies that: (a) a histological diagnosis of carcinoma of the cervix has been made; and (b) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63473	MRI—scan of the pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater, if the request for the scan identifies that: (a) a histological diagnosis of carcinoma of the cervix has been made; and (b) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $627.20 **Benefit:** 75% = $470.40 85% = $542.50
63476	MRI—scan of the pelvis for the initial staging of rectal cancer, if: (a) a phased array body coil is used; and

I5. MAGNETIC RESONANCE IMAGING	20. SCANS OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS
	(b) the request for the scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum) (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63740	MRI—scan to evaluate small bowel Crohn's disease if the service is provided to a patient for: (a) evaluation of disease extent at time of initial diagnosis of Crohn's disease; or (b) evaluation of exacerbation, or suspected complications, of known Crohn's disease; or (c) evaluation of known or suspected Crohn's disease in pregnancy; or (d) assessment of change to therapy in a patient with small bowel Crohn's disease (R) (Contrast) **Fee:** $457.20 **Benefit:** 75% = $342.90 85% = $388.65
63741	MRI—scan with enteroclysis for Crohn's disease if the service is related to item 63740 (R) **Fee:** $265.25 **Benefit:** 75% = $198.95 85% = $225.50
63743	MRI—scan for fistulising perianal Crohn's disease if the service is provided to a patient for: (a) evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn's disease; or (b) assessment of change to therapy of pelvis sepsis and fistulas from Crohn's disease (R) (Contrast) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

I5. MAGNETIC RESONANCE IMAGING	21. SCAN OF BODY - FOR SUSPECTED HEPATO-BILIARY OR PANCREATIC PATHOLOGY
	Group I5. Magnetic Resonance Imaging
	Subgroup 21. Scan Of Body - For Suspected Hepato-biliary or Pancreatic Pathology
63482	MRI—scan of pancreas and biliary tree for suspected biliary or pancreatic pathology (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63545	MRI – multiphase scans of liver (including delayed imaging, if performed) with a contrast agent, for characterisation or intervention planning, if: (a) the patient has: (i) known colorectal carcinoma; and (ii) known, suspected, or possible liver metastasis; and

I5. MAGNETIC RESONANCE IMAGING	21. SCAN OF BODY - FOR SUSPECTED HEPATO-BILIARY OR PANCREATIC PATHOLOGY
	(b) computed tomography, or ultrasound imaging, has identified a mass lesion in patient's liver. For any particular patient—applicable not more than once in a 12 month period (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $467.50
63546	MRI – multiphase scans of the liver (including delayed imaging, if performed) with a contrast agent, for diagnosis or staging, if: (a) the patient has: (i) known or suspected hepatocellular carcinoma; and (ii) chronic liver disease that has been confirmed by a specialist or consultant physician; and (b) the patient's liver function has been identified as Child Pugh class A or B; and (c) the patient has an identified hepatic lesion over 10 mm in diameter. For any particular patient—applicable not more than once in a 12 month period (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $467.50

I5. MAGNETIC RESONANCE IMAGING	22. MODIFYING ITEMS
	Group I5. Magnetic Resonance Imaging
	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.
63491	MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with clause 2.5.1; and (b) the item for the service includes in its description '(Contrast)'; and (c) the service is performed using a contrast agent (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
63494	MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with clause 2.5.1; and (b) the service is performed using intravenous or intra muscular sedation (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
63496	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. MRI service to which item 63545 or 63546 applies if: (a) the service is performed on a person under the supervision of an eligible provider; and (b) the service is performed using an hepatobiliary specific contrast agent (See para IN.0.19 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
63497	MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with clause 2.5.1; and (b) the service is performed under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic (See para IN.0.19 of explanatory notes to this Category) **Fee:** $156.80 **Benefit:** 75% = $117.60 85% = $133.30
63498	MRI service to which item 63501, 63502, 63504 or 63505 applies if: (a) the service is performed in accordance with the determination; and (b) the service is performed on a person using intravenous or intra muscular sedation (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
63499	MRI service to which item 63501, 63502, 63504 or 63505 applies if: (a) the service is performed in accordance with the determination; and (b) the service is performed on a person under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic. (See para IN.0.19 of explanatory notes to this Category) **Fee:** $156.80 **Benefit:** 75% = $117.60 85% = $133.30

	Group I5. Magnetic Resonance Imaging
	Subgroup 32. Magnetic Resonance Imaging - Pip Breast Implant
63501	MRI – scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) the result of the scan confirms a loss of integrity of the implant. (R) Note: Benefits are payable on one occasion only in any 24 Month Period (See para IN.0.19 of explanatory notes to this Category)

I5. MAGNETIC RESONANCE IMAGING	32. MAGNETIC RESONANCE IMAGING - PIP BREAST IMPLANT
	Fee: $500.00 **Benefit:** 75% = $375.00 85% = $425.00
63502	MRI - scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) the result of the scan does not demonstrate a loss of integrity of the implant (R) Note: Benefits are payable on one occasion only in any 24 Month Period (See para IN.0.19 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
63504	MRI - scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) presents with symptoms where implant rupture is suspected; and (iii) the result of the scan confirms a loss of integrity of the implant (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
63505	MRI - scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) presents with symptoms where implant rupture is suspected; and (iii) the result of the scan does not demonstrate a loss of integrity of the implant (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00

I5. MAGNETIC RESONANCE IMAGING	33. SCAN OF BODY - PERSON UNDER THE AGE OF 16 YEARS - GENERAL PRACTICE REQUESTS
	Group I5. Magnetic Resonance Imaging
	Subgroup 33. Scan of Body - Person Under the Age of 16 Years - General Practice Requests
63507	MRI—scan of head for a patient under 16 years if the service is for: (a) an unexplained seizure; or (b) an unexplained headache if significant pathology is suspected; or

	33. SCAN OF BODY - PERSON UNDER THE AGE OF 16 YEARS - GENERAL PRACTICE REQUESTS
I5. MAGNETIC RESONANCE IMAGING	
	(c) paranasal sinus pathology that has not responded to conservative therapy (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63510	MRI—scan of spine following radiographic examination for a patient under 16 years if the service is for: (a) significant trauma; or (b) unexplained neck or back pain with associated neurological signs; or (c) unexplained back pain if significant pathology is suspected (R) (Contrast) (Anaes.) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63513	MRI—scan of knee for internal joint derangement for a patient under 16 years (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63516	MRI—scan of hip following radiographic examination for a patient under 16 years if any of the following is suspected: (a) septic arthritis; (b) slipped capital femoral epiphysis; (c) Perthes disease (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63519	MRI—scan of elbow following radiographic examination for a patient under 16 years if a significant fracture or avulsion injury, which would change the way in which the patient is managed, is suspected (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63522	MRI—scan of wrist following radiographic examination for a patient under 16 years if a scaphoid fracture is suspected (R) (Contrast) (Anaes.) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80

	34. SCAN OF BODY - PERSON OVER THE AGE OF 16 YEARS - GENERAL PRACTICE REQUESTS
I5. MAGNETIC RESONANCE IMAGING	
	Group I5. Magnetic Resonance Imaging
	Subgroup 34. Scan of Body - Person Over the Age of 16 Years - General Practice Requests
Amend 63551	MRI - scan of head for a patient 16 years or older, after a request by a medical practitioner (other than a specialist or consultant physician), for any of the following: (a) unexplained seizure(s); (b) unexplained chronic headache with suspected intracranial pathology (R) (Contrast)

I5. MAGNETIC RESONANCE IMAGING	**34. SCAN OF BODY - PERSON OVER THE AGE OF 16 YEARS - GENERAL PRACTICE REQUESTS**
	(Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
Amend 63554	MRI - scan of spine for a patient 16 years or older, after referral by a medical practitioner (other than a specialist or consultant physician), for suspected cervical radiculopathy (R) (Contrast) (Anaes.) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
Amend 63557	MRI - scan of spine for a patient 16 years or older, after referral by a medical practitioner (other than a specialist or consultant physician), for suspected cervical spinal trauma (R) (Contrast) (Anaes.) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
Amend 63560	MRI - scan of knee following acute knee trauma, after referral by a medical practitioner (other than a specialist or consultant physician), for a patient 16 to 49 years with: (a) inability to extend the knee suggesting the possibility of acute meniscal tear; or (b) clinical findings suggesting acute anterior cruciate ligament tear (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
I6. MANAGEMENT OF BULK-BILLED SERVICES	
	Group I6. Management Of Bulk-Billed Services
Fee 64990	A diagnostic imaging service to which an item in this table (other than this item or item 64991) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; 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 IN.0.19 of explanatory notes to this Category) **Fee:** $14.30 **Benefit:** 85% = $12.20
Fee 64991	A diagnostic imaging service to which an item in this table (other than this item or item 64990) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and

I6. MANAGEMENT OF BULK-BILLED SERVICES	
	(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 within Modified Monash areas 2 to 7. (See para IN.0.19, AN.0.19 of explanatory notes to this Category) **Fee:** $21.60 **Benefit:** 85% = $18.40

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